NATIONAL Spine & Pain CENTERS
www.treatingpain.com

PATIENT REGISTRATION

Account #: _____
Home Phone #: (____) _____
Cell Phone #: (____) _____
Email Address*: _____

First M.I. Last

Patient's Name: _____ DOB: _____ Sex: ____ Date of Illness/Injury: _____
Address: _____ City: _____ State: _____ Zip Code: _____
SS #: _____ Marital Status: _____ Preferred Language: _____ Race: _____
Name of referring doctor: _____ Phone #: (____) _____ ☐ Not applicable
Employer: _____ Work Phone #: (____) _____
Address: _____ City: _____ State: _____ Zip Code: _____
Spouse's Name: _____ Spouse's Employer: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Nearest relative not living with you: _____ Phone #: (____) _____

HEALTH INSURANCE COVERAGE - *To be completed by all patients.* (In the case of workers' compensation, this information will only be used if your compensation is denied).

Health Insurance Company Name: _____ Effective Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone #: (____) _____ Group #: _____ ID #: _____
Subscribe is: ☐ Self ☐ Spouse ☐ Parent ☐ Other Subscriber's Name: _____
Social Security # of Subscriber *(if other than self)*: _____ DOB of Subscriber: _____
Do you have secondary insurance? ☐ Yes ☐ No Carrier Name: _____ ID #: _____

LIABILITY -*Please complete this section if your illness/injury is the result of an **accident** (auto or otherwise – but NOT work related). Please provide us with the med-pay/PIP benefits of your policy.*

Insurance Company Name: _____ Date of Accident: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Policy Number: _____ Claim #: _____
Claims Adjuster: _____ Phone #: (____) _____
Location of Accident *(State)*: _____

WORKERS COMPENSATION – *Please complete this section if your illness/injury is **work related**.*

Insurance Company Name: _____ Date of Accident: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Claims Adjuster: _____ Phone #: (____) _____ Claim #: _____
Rehab Nurse *(if applicable)*: _____ Phone #: (____) _____
Employer at the time of the accident: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Contact Person: _____ Phone #: (____) _____
When was the First Report of Accident filed? _____

ATTORNEY – *Please complete if an attorney is representing you regarding this particular illness/injury.*

Attorney Name: _____ Phone #: (____) _____
Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT AUTHORIZATION AND ASSIGNMENT

I, _____, hereby authorize Physical Medicine Associates, Ltd., doing business as National Spine & Pain Centers (hereby referred to as NSPC), to apply for benefits on my behalf for services rendered. I request that payment be made directly to NSPC. I certify that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to my insurance companies. I permit a copy of this authorization an assignment to be used in place of original. This will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fees. I understand that NSPC may refer me to a facility in which it has a financial interest. I am not obligated to use that facility and may make my appointment at another one of my choice.

Date: _____ Signature: _____

*Providing your email address authorizes NSPC to send electronic correspondence to you. You may unsubscribe at any time.

NATIONAL Spine & Pain CENTERS

NEW PATIENT QUESTIONNAIRE

***Office use only*

Provider _____ Appt time _____

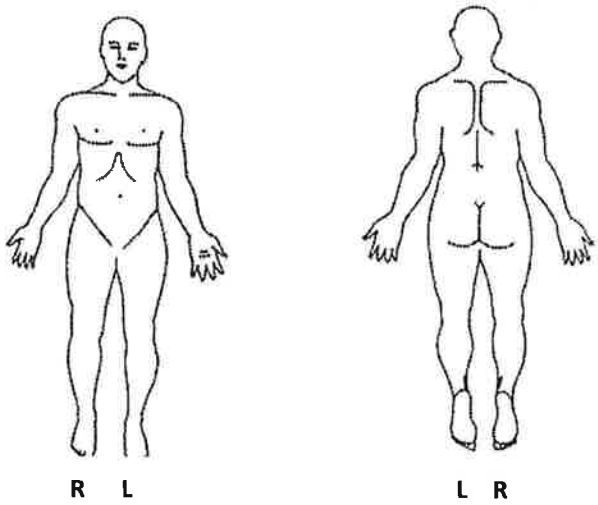
Patient Name _____ **DOB** _____ **Date** _____

Primary Care Physician _____ **Referring Physician** _____

This visit is related to a: ☐ Workers' Compensation injury ☐ Motor Vehicle Accident

Chief Complaint (reason for visit)_____ **Side** ☐ right ☐ left

On the diagram, shade in the areas where you feel pain?



R L L R

Current Pharmacy

Name: _____

Address: _____

Phone: _____

The onset of your pain was: ☐suddenly following an injury ☐suddenly without an injury ☐gradually following an injury ☐gradually without an injury ☐after a work related injury ☐after a motor vehicle accident

Your pain has been occurring for: _____ ☐days ☐weeks ☐months ☐years

Your pain occurs: ☐intermittent ☐continuous ☐occasional ☐rare

Describe your pain: ☐throbbing ☐dull ☐aching ☐shooting ☐stabbing ☐burning

Is your pain: ☐mild ☐moderate ☐severe ☐unbearable

Pain level today 0 1 2 3 4 5 6 7 8 9 10 (0 = no pain 10 = unbearable pain)

Over the last 2 weeks, please identify your pain levels below:

Severe pain level 0 1 2 3 4 5 6 7 8 9 10

Average pain level 0 1 2 3 4 5 6 7 8 9 10

Do you experience: ☐numbness ☐weakness ☐tingling ☐pins/needles ☐burning ☐swelling

What activities increase your symptoms:

☐sitting
☐standing
☐walking
☐lifting
☐ bending forward
☐ bending backward
☐bending to the right
☐bending to the left
☐driving
☐ cold/damp weather
☐ coughing/sneezing

What activities decrease your symptoms:

☐nothing
☐sitting
☐standing
☐walking
☐rest
☐avoiding strenuous activity
☐lying with pillow between
☐legs
☐heat
☐ice application
☐stretching
☐ pain medication
☐ massage
☐chiropractic manipulation
☐acupuncture
☐swimming

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NEW PATIENT QUESTIONNAIRE

Medications tried:

☐Oral NSAIDS (Ibuprofen/prescription strength Motrin)
☐Over the counter agents (Tylenol/Aspirin)
☐Muscle relaxants (Flexeril/Skelaxin)
☐Prescription pain medications (Vicodin/Dilaudid)
☐Prescription nerve medications (Lyrica/Cymbalta)
☐Prescription topical agents (Voltaren gel/Lidoderm patch)

Previous conservative measures

☐physical therapy
☐chiropractic treatment
☐cortisone injections
☐surgical intervention
☐activity modification
☐bracing
☐massage
☐acupuncture

ALL CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER (please list): _____

_____

_____

ALLERGIES (include allergies/side effects to medications or seafood): _____

_____

PAST MEDICAL HISTORY: Please check any of the following conditions you have or have had:

☐headaches ☐stroke ☐TMJ ☐thyroid disease ☐cancer ☐lung disease/asthma ☐blood clots
☐high blood pressure ☐peripheral vascular disease ☐heart attack ☐coronary artery disease ☐diabetes
☐gastrointestinal disease ☐stomach ulcers ☐kidney disease ☐hepatitis A ☐hepatitis B ☐hepatitis C
☐fracture ☐arthritis ☐neurologic disorders ☐pinched nerves ☐seizures ☐ HIV/AIDS

Please list any other past or present medical conditions you have: _____

Please indicate any prior accidents or work injuries: _____

PAST SURGICAL HISTORY: _____

FAMILY HISTORY: ☐None ☐Unknown Please list all medical conditions that are common in your family:

☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other: _____ _____
☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other: _____ _____
☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other: _____ _____
☐Father ☐Mother ☐ Brother ☐ Sister ☐ Other: _____ _____

SOCIAL HISTORY:

Occupation: _____ ☐Full-time ☐Part-time ☐Retired ☐Not Working

Marital Status: ☐S ☐M ☐W ☐D ☐P Tobacco use: ☐Yes ☐No Former smoker: ☐Yes ☐No

Alcohol use: ☐Yes ☐No Do you have problems with drug or alcohol use or dependency? ☐Yes ☐No

REVIEW OF SYSTEMS - PROBLEMS EXPERIENCING AT THE PRESENT TIME:

☐Fever ☐Dry Eye ☐Dry Mouth ☐Leg Swelling ☐Shortness of Breath
☐Constipation ☐Involuntary Urine Loss ☐Poor Balance ☐Dry Skin ☐Joint Swelling
☐Sleep Disturbance ☐Depression ☐Anxiety ☐ Weight Loss ☐Easy Bleeding ☐Rash

The above information is accurate to the best of my knowledge:

Patient Signature: _____ Date: _____

NATIONAL Spine & Pain CENTERS

Patient Name _____ **Patient ID** _____

DOB _____ **Date** _____

NSPC is dedicated to providing comprehensive care to patients and following the federal guidelines regarding important public health issues. *Please circle your answer to the following questions.*

SECTION 1: DEPRESSION

Over the last 2 weeks, how often have you been bothered by the following problems?

Are you currently being treated for a diagnosis of depression?	YES	NO

If you answered Yes to the above question please DO NOT COMPLETE the remainder for Section 1

	Not At All	Several days	More than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

SECTION 2: ADVANCED DIRECTIVE

Are you age 65 or older?	YES	NO

In the event that you are incapacitated, who would you like to have make your medical decisions? *Provide name, phone number, and relationship. If none assigned, leave blank.*

_____

SECTION 3: FALL RISK

Please circle "Not Applicable" if you Use Wheelchair for Mobility or are Unable to Walk

Do you feel unsteady when walking? YES NO NOT APPLICABLE (N/A)

Do you worry about falling? YES NO NOT APPLICABLE (N/A)

Have you fallen in the past 1 year? YES NO

If yes, how many falls? 1 2 3 or more falls

Were you injured during any of the falls? YES NO

SECTION 4: TOBACCO USE

Are you currently smoking cigarettes or using other tobacco products? YES NO

SECTION 5: BLOOD PRESSURE

Have you ever been diagnosed with high blood pressure (Hypertension)? YES NO

Patient Signature: _____ Date _____

NATIONAL Spine & Pain CENTERS

Patient Name _____ **Patient ID** _____

DOB _____ **Date** _____

SECTION 5: HYPERTENSION (continued from page 1)

BP: Systolic _____ / Diastolic _____

SECTION 6: BODY MASS INDEX

What is your height? _____feet _____inches What is your weight? _____lbs.

Official Use Only **BMI =**

SECTION 7: Medication Documentation

Official Use Only *See Medication List is Patient Chart.*

SECTION 8: Pain Assessment

Official Use Only *See pain scale in office note*

Completed by staff member: _____

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☐ Fairfax	☐ Lansdowne	☐ National Harbor	☐ Washington DC
☐ Fredericksburg	☐ Lynchburg		☐ Woodbridge

Welcome and thank you for selecting ***National Spine and Pain Centers.***

Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner. Listed below are some guidelines for your review. Throughout the time you receive services from our organization, please feel welcome to contact any member of our team with questions or need for any information.

Wishing you good health,

The Physicians & Staff at National Spine and Pain Centers

Guidelines

- **Primary Care Referrals**: Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.
- **Co-Payments**: Co-payments and deductibles must be paid upon the patient's arrival. We accept checks, debit cards, Visa, and MasterCard.
- **Non-covered services** (prolotherapy, acupuncture, supplies and equipment) must be paid for at the time of service.
- **Tardiness**: Please call if you are running late. Patients arriving more than 15 minutes late may be asked to reschedule. Obviously, we try to deliver the same respect for your time - if we are running late, the session will be completed in its entirety.
- **Cancellations**: We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other patients that could benefit from this treatment slot. Patients that do not contact the office within the 24 hour period to cancel their appointment will be charged a $75 fee for the missed appointment.
- **Repeated Missed Appointments**: We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan.
- **Medication Refills**: To ensure that your medication needs are met in a timely manner, we request that you notify us at least three (3) days prior to the date your medication is scheduled to run out. There will be a $15.00 fee assessed when a prescription is obtained prior to a scheduled appointment.
- **Easy Pay Agreement**: National Spine and Pain Centers will keep your signature and credit card/debit card information-on-file for automatic payment of your outstanding balance.

_____ _____

Signature of Patient or Responsible Party Date

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CLAIMS, PAYMENT AND REVIEWS POLICY

Thank you for selecting National Spine & Pain Centers as your health care provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our claims, payment and review policies which we require you to read and sign prior to any treatment.

Full payment for professional services is due at the time of service. We accept checks, Visa, MasterCard or Discover.

Our practice participates with most insurance carriers. As a courtesy, we will contact your carrier to confirm coverage and estimate their payment for services rendered.

I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benefit(s) plan to National Spine & Pain Centers for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance company or health maintenance organization does not consider the services received as covered or has not authorized the services, then I will be fully responsible for the service provided. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay larger co-pay, co-insurance or other charges. In the event that the insurance does not reimburse these services provided, I acknowledge that I will be responsible for any balance that it declines to pay for such services _____ (initials).

We require you to make your payment at time of service. Prompt payment allows us to control costs which ultimately keep our fees to a minimum. Patients with a standard co-payment (i.e. $10.00, $12.00 or $15.00 per visit) are required to pay this at the time of service. Patients whose co-insurance is based upon a percentage of the charge are required to pay an estimated percentage of their bill at the time of service. This payment will be applied toward your ultimate responsibility. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible. We require you to pay your deductible at the time of service.

NOTICE TO TRICARE BENEFICIARIES

If you are a TRICARE beneficiary, the prior two paragraphs do not apply to you. When you visit one of our physicians or physician's assistants, please identify yourself as a TRICARE beneficiary. If the services to be rendered to you are excluded from your TRICARE benefits, your payment options for these excluded services will be discussed with you at the time of your visit. If the services to be rendered to you are covered as TRICARE benefits, your only charge will be the applicable deductible, copayment and/or cost-sharing amount.

If you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. If your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you are asked to assist us in contacting your insurance carrier.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area.

As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. As required by insurance mandates you are also responsible to obtain the appropriate authorizations for medical treatment.
In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

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I authorize release of information, including financial information and confidential health information and medical records for services rendered regarding my injury or any other services, which may include records related to treatment for substance abuse, to my insurance carrier(s), managed care plan or other pay or, including past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying obligations of state or federal law.

There is a $15 charge for prescription refills prior to a scheduled appointment and a $75 charge for No Show or Call to Cancel appointments with less than a 24 business hour notice.

Returned checks will be processed with a service charge of $35. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Our staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, coverage issues are best addressed by your employer or group plan administrator. Your insurance policy is a contract between you and your insurance carrier. National Spine & Pain Centers is not a party to that contract and cannot act as a mediator with the carrier or your employer.

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

Disclosure of Financial Relationships: Physical Medicine Associates LTD, doing business as Capital Spine & Pain Centers and/or its associated physicians (collectively "National Spine") have financial interests and/or financial relationships with the following entities:

- Meditech, LLC- rents office space from National Spine, sells braces to National Spine and provides brace fitting services to National Spine
- Center for Pain Management, LLC- National Spine and Pain Centers Holdings, LLC is a parent company of National Spine and the Center for Pain Management, LLC. The Center for Pain Management, LLC operates a clinical laboratory in Columbia, Maryland, which maintains the following credentials and accreditations:
  - Centers for Medicare and Medicaid Services Certificate of Compliance with a specialty in toxicology
  - COLA Laboratory Accreditation.

All patients have a right to choose where and from whom they receive health care services. If you would prefer to use another health care provider for laboratory, durable medical equipment or otherwise, please let our staff know. We can recommend other health care providers and/or work with your preferred health care providers.

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to call 703-914-8000.

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

_____
Patient Name (please print)

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witnessed by NSPC Representative Date

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YOU AND THE HIV VIRUS

We are all concerned with minimizing the risks of exposure to the HIV virus.

We are very conscientious about this at National Spine & Pain Centers. We have very careful protocols that comply with government regulations for safely (monitored by the Occupational Health and Safety Administration). We would like you to know that we use disposable needles, and you are at no time exposed to blood or bodily fluid s of any other patient.

We are obligated to provide a safe workplace. This ensures a safe treatment environment for you. There may be an occasion when we are accidentally in contact with your blood or other bodily fluids. If such an incident occurs at our Virginia or DC offices, we may test your blood for HIV and may release the results of the test to the employee who may have been exposed. If such an incident occurs at our Maryland office, we may obtain your informed consent to test your blood for HIV.

Again, these precautions are taken in the interest of safety for you and our staff members.

Please sign below that you understand this information.

_____ _____

Patient Signature Date

Notice of Privacy Practices Pursuant to 45 C.F.R. §164.520

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("PHI"). PHI consists of individually identifiable health information, which may include demographic information we collect from you or create or receive by another health care provider, a health plan, your employer, or a health care clearinghouse, and that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

We must provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to PHI and make new privacy policies effective for all PHI that

NATIONAL Spine & Pain CENTERS

current Notice of Privacy Practices in the waiting room, and keep a copy of the revised Notice at the registration desk, and provide you with a copy upon your request, and if we maintain a website, we will post our Notice of Privacy Practices on our website.

Examples of Uses and Disclosures of Your PHI relating to Treatment, Payment & Operations

HIPAA privacy regulations give us the right to use and disclose your PHI without your consent to carry out (i) treatment, (ii) payment, and (iii) health care operations. Here are some examples of how we intend to use of your PHI in regard to your treatment, payment, and health care operations.

Treatment. In connection with treatment, we will, for example, use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will disclose your PHI to other providers who may be treating you. Additionally, we may disclose your PHI to another provider who has been requested to be involved in your care.

Payment. We will use your PHI to obtain payment for our services, including sending claims to your insurer or to a federal program, such as Medicare, that pays for your treatment and sending you a bill for any amounts due which your insurer does not pay. We may also employ Business Associates, such as a billing company or collection agency to help us bill and collect. The PHI will include items such as description of your condition(s), our treatment, your diagnosis, supplies and drugs we used, etc.

Health Care Operations. We will use your PHI to support our business activities, such as allowing our auditors, consultants, or attorneys access to your PHI to audit our claims to determine if we billed you accurately for the services we provided to you, or to evaluate our staff to see if they properly cared for you, or to send information about you to third party Business Associates so they may perform some of our business operations.

Description of Other Required or Permitted Uses and Disclosures of Your PHI

Appointment Reminders. We will call you to remind you of an appointment. We may call your residence, office, or any other number we have on file. We will leave a message if you are not in, and we will state the name of.

National Spine and Pain Centers
3031 Javier Road, Suite 200
Fairfax, VA 22031
P 703 914.8000 **F 703** 642.1876

our clinic, the date and time of the appointment, and the address at which the appointment is to be kept. We may also mail you a notice of your appointment to any address we have on file

As Required by Law. We will use and disclose your PHI when required to by federal, state, or local law. For example, we may receive a subpoena for which we are required by law to provide copies of your medical file.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your PHI to public health authorities permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers Compensation. We will use and disclose your PHI for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. If you are an inmate, we will use and disclose your PHI to a correctional institution or law enforcement official only if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Other Services and/or Fundraising. We may use your PHI to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your PHI to contact you in an effort to raise funds for our operations; however, you have the right to opt out of receiving any fundraising communications by sending a letter to our Privacy Officer in writing at the address at which you are treated.

NATIONAL Spine & Pain CENTERS

Rev 10/28/14

Uses and Disclosures to which You have an Opportunity to Object

Others Involved in Your Care. We may provide relevant portions of your PHI to a family member, a relative, a close friend, or any other person you identify as being involved in your medical care or payment for care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being involved in your care or payment for your care, by voluntarily bringing them in the room. If you do not object to us discussing your PHI in front of them, we may discuss your PHI in their presence because you did not object. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it after the emergency, and give you the opportunity to object to future disclosures to family and friends.

Uses and Disclosures that Require Your Signed Authorization

There are certain uses and disclosures of your PHI that require your written authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI require your signed authorization. Also, any use or disclosure of your PHI not described in this Notice requires your signed authorization.

Your Right to Revoke Your Authorization

If you sign an authorization allowing us to use or disclose your PHI outside of the uses and disclosures made in this Notice, you may revoke that authorization by advising us in writing with a letter addressed to Privacy Officer, at the address where we treat you. Your revocation will become effective as soon as we are reasonably able to enter it into our records, which is typically within 5 business days after we receive the letter. Your revocation will not affect our prior reliance on your authorization prior to the effective date of revocation.

Your Right to Restrict Certain PHI to a Health Plan

You have the right to require us to restrict any disclosure of your PHI to a health plan regarding an item or service for which you (or someone on your behalf - other than a health plan) paid out-of-pocket to us the entire amount due for the health care item or service which we provided and billed to you. You must make such a request in writing to us, with a letter addressed to Privacy Officer at the address where you receive your treatment. If you make such a request, we are required to honor it.

Notification in Case of Breach of Unsecured PHI

In the event of an unauthorized or improper use or disclosure of your PHI (i.e., a "breach"), you have the right to receive, and we will notify you of the circumstances surrounding, the breach, what we have done to investigate and mitigate it, and how to best protect yourself in our opinion.

Patient Rights Related to PHI

In addition to your other rights provided herein, you have the right to:

Request an Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating what information is incomplete or inaccurate and the reasoning that supports your request. We are permitted to deny your request if it is not in writing or does not include a reason that we believe supports the request. We may also deny your request if the information was not created by us or the person who created it is no longer available to make the amendment.

Request Restrictions. You have the right to request a restriction of how we use or disclose your medical information for treatment, payment, or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to the Privacy Officer addressed to the address at which you receive care. We are not required to agree to your request. If we do agree, we will comply with your request except for emergency treatment. Inspect and Copy. You have the right to inspect and copy the PHI we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. If you wish to inspect or copy your medical information, you must submit your request in writing to our Privacy Officer at address at which you receive treatment. We will have 30 days to respond to your request for information that we maintain at our facility. . If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay. HITECH expands this right, giving individuals the right to access their own e-health record in an electronic format if we maintain your records in an electronic format, and to direct us to send the e-health records directly to a third party.

We may only charge for labor costs under electronic transfers of e-health records.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made that were not for treatment, payment, or health care operations. Your request must be in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003, nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests; however, we will not accommodate a request that we perceive is an attempt to avoid receiving notice of a bill for the payment of our services.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us or directly to the Secretary of the United States Department of Health and Human Services: U.S. Department of Health & Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201, Phone: (202) 619-0257, Toll Free: (877) 696-6775. To file a complaint with us, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to our Privacy Officer at the address at which you were treated. No patient will be retaliated against for making a complaint.

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking for it.

Contact Person

You may contact our Privacy Officer at the following phone number for any questions:
703.914.8000
Ext 3320

Effective Date

The effective date of this revised Notice of Privacy Practices is September 13, 2013.