VIRGINIA OBSTETRICS & GYNECOLOGY P.C.

Patient Name: _____
(Print Clearly)

Date of Birth: _____/_____/_____

MY PREFERRED CONTACTS

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. You may update or change this information at any time; please do so in writing.

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. You have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below. Please update this information in writing promptly if your preferences change.

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

- Name:_____Telephone:_____
  Relationship:_____ Email:_____
- Name:_____Telephone:_____
  Relationship:_____ Email:_____
- Name:_____Telephone:_____
  Relationship:_____ Email:_____

NOTE: If I have provided email addresses for my Preferred Contact, my signature below indicates that I understand and acknowledge that e-mail communication is not secure. E-mails can be intercepted during transmission; and 2) unencrypted messages (and any attachments) can be read, and potentially copied and forwarded, by anyone. Encrypted emails can also be easily viewed by someone other than the recipient. If, for example, I access messages via a smartphone or tablet.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

PRIVACY NOTICE ACKNOWLEDGEMENT

At Virginia Obstetrics and Gynecology, we follow strict HIPAA regulations. We will never sell or give your information to any other person without your request. By signing this form, you acknowledge that you will review, understand, and comply with Virginia Obstetrics & Gynecology Patient's Privacy Acknowledgement regulated by the Health Insurance Portability and Accountability Act.

***IF YOU WOULD LIKE A COPY OF THE HIPAA AND PIH ACT PLEASE ASK THE FRONT DESK ***

Please be advised, we cannot give information to anyone without your written consent.

I give permission to Virginia Obstetrics & Gynecology, P.C. to speak with the person(s) listed below regarding my medical care.

Authorized Person(s)	Relationship to Patient	Phone Number
1.		( ) -
2.		( ) -

I authorize Virginia Obstetrics & Gynecology to leave a voicemail message at the following number. Messages may at times include health information, including appointment reminders, test results, and instructions. I understand that with my signature I am authorizing the release of verbal communication by Virginia Obstetrics & Gynecology to the voicemail numbers.

Home/Work: _____ Cell: _____Email:_____

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

VIRGINIA OBSTETRICS & GYNECOLOGY P.C.

Patient Name: _____
(Print Clearly)

Date of Birth: _____/_____/_____

FINANCIAL POLICIES

This is to advise you of our UPDATED billing policies regarding services provided by Virginia Obstetrics & Gynecology that are not covered by your insurance plan. It is the policy of Virginia Obstetrics & Gynecology to bill appropriately and accurately for the services provided to the insurance plans in which we participate. We reserve the right to charge for specific services not covered by insurance.

The Fees Are As Follows:

Missed Appointments Without 24-Hour Notice: $50 Per Occurrence

Late Arrival of 15 Minutes or More: $50 Per Occurrence

Work Related Forms/Disability Forms/FMLA Fee: $35.00 per form with a processing time of 7-10 days

Medical Records: $35.00 for Paper or Electronic Records with a processing time of 14 days

Non-Emergency After Hours Call: $50 Per Occurrence

Return Check Fee: $75 Per Occurrence

Surgery Cancellation Fee: $200 Per Occurrence

Payment of outstanding balances, including, but not limited to; insurance deductibles,missed appointment fees, insurance copays, and any other balance not covered by insurance, must be paid prior to or upon the date of service. There will be no exceptions unless prior arrangements have been made.

INSURANCE COPAYS ARE DUE AT THE TIME OF YOUR APPOINTMENT. **PLEASE ARRIVE TO EACH APPOINTMENT WITH YOUR INSURANCE CARD AND PHOTO ID.**

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

REFILL POLICY

Effective as of August 1, 2023 Virginia Obstetrics and Gynecology has implemented a new refill policy.

Approval of refills may take up to 5 business days!

- **Refills are to be requested once patient is down to zero refills to allow time for:**
  - Follow Up Appointments
  - Lab Work
  - Doctor Approval
- **Patient requesting new prescriptions or antibiotics must be seen for an appointment**
- **It is important to keep your scheduled appointment to ensure that you receive timely refills**
  - Repeated no shows or cancellations will result in a denial of refills
- **Medication refills will only be addressed during regular office hours**
  - No prescriptions will be refilled on Saturdays, Sundays, and Holidays

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

VIRGINIA OBSTETRICS & GYNECOLOGY P.C.

Patient Name: _____
(Print Clearly)

Date of Birth: _____/_____/_____

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Address_____ **City, State & ZIP Code** _____

Patient's Phone Number _____**Any Other Names Used** _____

I request that my provider share my Protected Health Information
Name _____

Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Patient's Telephone Number: _____ **Other Names Used:** _____

I request that my provider share my Protected Health Information (PHI) as directed below. Specifically, I request that my PHI:

1) From the following Care Center locations and/or providers (list all locations) _____
_____
2) Be sent to
☐ Virginia Obstetrics and Gynecology (19490 Sandridge Way, Suite 350 Lansdowne, Virginia 20176)
☐ _____
3) I hereby authorize disclosure of the following information:
☐ My entire medical record ☐ Immunization Records Only ☐ My Service Dates Only: _____ to _____
☐ Specific Information Only: _____
_____

NOTES: 1) INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, HIV/AIDS AND MENTAL HEALTH ISSUES IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED IN THE SPACE BELOW. PSYCHOTHERAPY NOTES, HOWEVER, ARE NEVER INCLUDED. 2) IF YOU REQUEST WE SEND ONLY A PORTION OF YOU RECORDS TO A TREATING PROVIDER

☐ PLEASE EXCLUDE THE FOLLOWING INFORMATION FROM THE RECORDS SENT: _____
_____ SIGNATURE: _____

4) I understand I have the right to receive a copy of my PHI in the form, format, and manner that request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below I understand that my PHI will be mailed to me at the address listed above in hard copy (paper) format.**
5) If I have requested records be sent in an unencrypted format, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
6) If I have requested my records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive similar device, I will be charged for the cost of that device.
7) I understand that the information disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will no longer be protected by federal privacy regulations.
8) I understand I may revoke this authorization by notifying my provider OR privacy@priviahealth.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reverse, and my revocation will not affect those actions.
9) I understand that my care and treatment may not be conditioned on providing this authorization, if such condition is prohibited by the HIPAA Privacy Rule
10) My purpose/use of the information is for personal use or other (please specify) _____
11) This authorization expire _____, 20_____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of the information about me (please describe/specify event). If no expiration date is provided, this authorization will expire one year from the signed date.

NOTE FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filed.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature Of Patient _____ **Today's Date** _____/_____/_____

Signature Patient's Legal Guardian Or Personal Representative Of Patient's Estate _____

Description Of Authority to Act for this Individual _____ **Today's Date** _____/_____/_____

VIRGINIA OBSTETRICS & GYNECOLOGY P.C.

Patient Name: _____
(Print Clearly)

Date of Birth: _____/_____/_____

PATIENT INFORMATION SHEET

Personal Information

Address, City, State & ZIP Code _____

SSN _____ Marital Status S M Sep W D

Home _____ Cell _____

Employer _____ Occupation _____

Spouse Name _____ Phone Number _____

Referred By _____ Reason _____

Preferred Pharmacy Name/ Location_____

Preferred Radiology Center Fairfax Radiology (Leesburg) Washington Radiology (Sterling) Other _____

Insurance Information

Primary Insurance Company _____ Effective Date _____/_____/_____

Member ID _____ Group Number _____

Address _____ Phone Number _____

Secondary Insurance Company _____ Effective Date _____/_____/_____

Member ID _____ Group Number _____

Address _____ Phone Number _____

Person Responsible For Payment or Insurance Policyholder (If Other Than Patient) Information

Policyholder Name _____ Relation to Patient _____

Policyholder Date Of Birth _____/_____/_____ Marital Status S M Sep W D

Address, City, State & ZIP Code _____

SSN _____

Home _____ Cell_____

Employer _____ Occupation _____

PATIENT CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:
I, The Undersigned, Consent To The Use And disclosure of my protected health information for treatment, payment, and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by Virginia Obstetrics & Gynecology, P.C. (the Practice). For those insurance plans for which the Practice accepts assignments. I accept personal responsibility for all co payments, deductibles. And non covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me, including attorney fees if necessary. I authorize payment directly to the Practice for services for which the Practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

Patient Signature: _____ **Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)