NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office | 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031 | p 703-876-0800 | f 703-876-0866
*Reston Office | 1830 Town Center Dr, Suite 305, Reston, VA 20190 | p 703-876-0800 | f 703-876-0866
neurologycenteroffairfax.com

Information for Our Patients

Thank you for choosing Neurology Center of Fairfax for your neurological care. Our goal is to provide you with the highest quality care. Please help us by providing your most up to date medical information prior to each visit.

Please be respectful of other patients and arrive 30 minutes before your initial visit or 15 minutes before a scheduled follow up visit. Please call us if you are delayed by traffic at 703-876-0800. If you are late, we may not be able to see you the same day. We understand the problems with traffic in Northern Virginia, but we cannot inconvenience patients who do arrive on time for their appointments.

For each visit:

- Please fill out all information and authorization forms before you come for your visit. Your doctor needs current information to provide you with the best possible care. Please download the necessary forms for your visit from our website www.neurologycenteroffairfax.com, or pick them up at our office so you can complete them ahead of time.

- Complete the specific disease information sheets if appropriate. (i.e., Multiple Sclerosis, Parkinson's, Sleep)

- Make a list of your questions and concerns prior to your visit and bring them with you so they can be addressed during your visit.

- Provide a complete and up-to-date written medication list with doses and the times your medications are taken. Include all over-the-counter medications, vitamins, and supplements.

- Get new prescriptions and prescription refills at the time of your visit. If you do not, you may need to schedule a refill visit with one of our nurses. We cannot accept prescription refill requests from pharmacies due to potential medication errors. Your prescriptions are your responsibility; make sure you receive the correct medication and the correct dose. There is a charge for emergency prescription refills between visits.

- Continued…

JAMES P. SIMSARIAN, M.D. | ROBERT N. KURTZKE, M.D. | MARCO D. CASTRO, M.D.
RICHARD C. SEESTEDT, JR., M.D. | AMY R. STONE, M.D. | CANDACE V. BRYAN, M.D. | MATTHEW R. CHURCHILL, M.D.
RANDOLPH R. STEPHENSON, M.D. | NICOLE A. E. DIETZ, M.D., PH.D. | RICHARD A. MONTI, JR., M.D. | MEAGAN ADAMSON, DNP, FNP-BC
*ROBERT RICHARD, M.D. | *MARK C. TEKRONY, M.D., PH.D. | *RICHARD L. CHO, M.D.

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- Your co-payment, co-insurance, and any deductible amounts you owe are due at the time of service. If you do not pay these costs at the time of your visit, there is a $10 administrative fee and an additional $10 service charge for each bill we send. These charges are not covered by health insurance. We accept VISA, MasterCard, Discover, cash or checks.

- If you must cancel your appointment, you are required to give at least 48-hour advance notice to the office, 72-hour notice is required for Sleep Study cancellations. If you miss your appointment or do not give adequate notice there is a $100 cancellation fee for new patients and testing, $50 for follow-up visits, and $300 for Sleep Studies.

- Our office does not communicate Personal Health Information (PHI) with patients or others via email or text messaging due to the HIPAA privacy law. You may use our web portal for secure communications with your doctor or our staff.

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Patient Authorizations

Patient Name: _____

Date of Birth: _____

(Please read carefully. You are authorizing these actions.)

I hereby authorize the Neurology Center of Fairfax, Ltd. (NCF) to apply for benefits on my behalf for covered services rendered by NCF, to myself or to my dependent. Authorization is effective as of today. I request payment from my insurance carrier and/or Medicare Part B to be made directly to NCF.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including protected health information (PHI) for this or any other related claim, to my insurance carrier or in the case of Medicare Part B benefits to the Social Security Administration and Centers for Medicare and Medicaid Services (CMS). I permit a copy of this authorization to be used in place of an original. It is possible that services provided to me by NCF may not be covered by Medicare or by my insurance. I agree to assume responsibility for full payment of all services if Medicare or other insurance payment is denied. I further agree to be responsible for the outstanding balance on this account and to pay all reasonable costs of collection including attorney's fees at 40% of the outstanding balance and monthly interest at 1.5%, should this account become overdue.

I understand that payment for all services is due and payable in full at the time of service, and that full payment for services may be required at the time of service. This includes, but is not limited to, my co-payment, co-insurance and deductibles. I agree to provide NCF with my current insurance card, government issued identification, and a valid referral (if required) at the time services are rendered. I understand that it is my responsibility to obtain required referrals.

I understand that although my insurance may pay part or all of the charges I incur, I am still ultimately liable and responsible for all charges. I understand that it is my responsibility to know the correct amount of my co-payment and deductible. I understand that my co-payments, co-insurance, and any deductibles are due at the time of service. I understand there is a $10 administrative fee if I do not pay my co-payment, co-insurance, and deductible at the time of service, and a separate $10 administrative fee each time a bill is generated for payment due, but not paid at the time of service. I understand I will be charged a "no-show" fee for any missed appointment, or any appointment not cancelled more than 48 hours in advance.

I authorize NCF to release my medical records (protected health information) to my treating physicians and other healthcare providers and to discuss my care with those providers, as my physician deems necessary. I authorize NCF to contact the people whom I list as emergency contacts in the event of an emergency. I authorize NCF to obtain contact information from my other health care providers, my emergency contacts, my employer or my health insurance carrier, if NCF is unable to contact me directly for any reason. I authorize my treating NCF physician to provide information to my caregiver or a family member, if my physician judges this disclosure to be important for my well-being. I authorize NCF to access my prescriptions in the Pharmacy Benefit Manager history. I authorize NCF to leave messages for me on answering devices attached to my telephones or to contact me by email or text message. I authorize NCF to contact me by email to inform me that information is available for me on the NCF secure patient portal. These authorizations may be revoked by me at any time in writing. I agree that a facsimile or a scanned copy of this agreement may be treated as an original for all purposes. I take these actions in Fairfax County, Virginia.

I acknowledge I have received a copy of the Neurology Center of Fairfax, Ltd.'s Notice of Privacy Practices dated February 28, 2023. I have read, I understand, and I agree to the terms and conditions specified in the Notice of Privacy Practices.

Signature:_____ **Date:** _____

****

****If the patient is under the age of 18, please complete the following:**
The undersigned is a parent/guardian of the patient and executes this form on behalf of the patient.

Name:_____ Relationship: _____

Signature:_____ Date: _____

For Patients Who Do Not Have Their Insurance Card, and/or Referral, If Required, (includes Work Comp)

I acknowledge that I did not bring a referral as required by my insurance company and/or do not have my insurance card. I am electing to be seen today and agree to pay in full today for the services rendered today since I do not have a valid referral and/or insurance card, or worker's comp authorization.
Signature:_____**Date:** _____

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New Patient Form

Name: _____ D.O.B: _____ Date: _____

Primary care doctor: _____ Primary care phone number: _____

Chronological history of illness

Type out or attach a chronological history of your illness. This is a written timeline of your symptoms from the beginning documenting the month and year in which they occurred and how they were treated. Then proceed with each significant symptom thereafter. Include the time, date and results of all imaging studies obtained that relate to your neurological illness. Continue on the next page if necessary.

Please include the following in the chronological history of your illness:

When did your symptoms first begin? _____

What symptoms did you have? _____

What new/additional symptoms have you had? _____

When did your symptoms first begin? _____

What has brought on your symptoms or made them worse? _____

Previously taken medications for your symptoms? _____

What tests have you done?

_____

_____

Written timeline/chronology:

_____

_____

_____

_____

_____

_____

_____

_____

Continued on next page

Name: _____ D.O.B: _____ Date: _____

Chronological History of Illness Continued

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Medication list

Name: _____ D.O.B.:_____ Date: _____

Mail order pharmacies

Name	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____

Local pharmacies

Name	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____

Prescriptions

If you need additional space, continue on the next page

Name	Dosage	Frequency	Reason for Taking	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Vitamins

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____

Over the counter medications

Name	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Name	Severity
_____	_____
_____	_____

Additional Medications/Vitamins/OTC:

Name	Dosage	Frequency	Reason for Taking	Prescribed by

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Review of Systems

Name: _____ **DOB:** _____ **Date:** _____

CONSTITUTIONAL SYMPTOMS		VISUAL SYMPTOMS		GYNECOLOGICAL SYMPTOMS	
Weight Change	☐YES ☐NO	Blurry vision	☐YES ☐NO	Other	☐YES ☐NO
Chills/fever	☐YES ☐NO	Double vision	☐YES ☐NO	**SLEEP SYMPTOMS**	
Fatigue	☐YES ☐NO	Loss of vision	☐YES ☐NO	Snoring	☐YES ☐NO
Other	☐YES ☐NO	Seeing flashing lights	☐YES ☐NO	Gasping at night	☐YES ☐NO
HEAD AND NECK SYMPTOMS		Other	☐YES ☐NO	Insomnia	☐YES ☐NO
Headaches	☐YES ☐NO	**EARS, NOSE, AND THROAT SYMPTOMS**		Daytime sleepiness	☐YES ☐NO
Facial pain	☐YES ☐NO	Hearing loss	☐YES ☐NO	Restless legs	☐YES ☐NO
Neck pain	☐YES ☐NO	Ringing in ears	☐YES ☐NO	Other	☐YES ☐NO
➥ Pain radiating to arms	☐YES ☐NO	Vertigo, dizziness, lightheadedness	☐YES ☐NO	**NEUROLOGICAL SYMPTOMS**	
Other	☐YES ☐NO		☐YES ☐NO	Headache	☐YES ☐NO
SKIN SYMPTOMS		Taste disturbance	☐YES ☐NO	Visual symptoms	☐YES ☐NO
Hives	☐YES ☐NO	Smell disturbance	☐YES ☐NO	Facial pain	☐YES ☐NO
Itching	☐YES ☐NO	Other	☐YES ☐NO	Memory lapse or loss	☐YES ☐NO
Rash	☐YES ☐NO	**GENITOURINARY SYMPTOMS**		Confusion/disorientation	☐YES ☐NO
Other	☐YES ☐NO	Urinary frequency	☐YES ☐NO	Generalized pain	☐YES ☐NO
HEMATOLOGICAL SYMPTOMS		Urinary urgency	☐YES ☐NO	Localized pain	☐YES ☐NO
Bleeding or bruising	☐YES ☐NO	Urinary loss of control	☐YES ☐NO	➥ Head	☐YES ☐NO
Other	☐YES ☐NO	Urinary tract infection	☐YES ☐NO	➥ Neck	☐YES ☐NO
RESPIRATORY SYMPTOMS		Sexual dysfunction	☐YES ☐NO	➥ Arms	☐YES ☐NO
Shortness of breath	☐YES ☐NO	Other	☐YES ☐NO	➥ Torso	☐YES ☐NO
Infections	☐YES ☐NO	**MUSCULOSKELETAL SYMPTOMS**		➥ Legs	☐YES ☐NO
Other	☐YES ☐NO	Back pain	☐YES ☐NO	Numbness	☐YES ☐NO
GASTROINTESTINAL SYMPTOMS		➥ Pain radiating to legs	☐YES ☐NO	➥ Head	☐YES ☐NO
Difficulty swallowing	☐YES ☐NO	Neck pain	☐YES ☐NO	➥ Neck	☐YES ☐NO
Abdominal pain	☐YES ☐NO	➥ Pain radiating to arms	☐YES ☐NO	➥ Arms	☐YES ☐NO
Ulcer disease	☐YES ☐NO	Joint pains	☐YES ☐NO	➥ Torso	☐YES ☐NO
Liver disease	☐YES ☐NO	Pain in arms/hands	☐YES ☐NO	➥ Legs	☐YES ☐NO
Bowel problems	☐YES ☐NO	Pain in legs/feet	☐YES ☐NO	Fatigue - feeling tired	☐YES ☐NO
Other	☐YES ☐NO	Muscle weakness	☐YES ☐NO	Tremor	☐YES ☐NO
ENDOCRINE SYMPTOMS		Muscle pain/aches	☐YES ☐NO	Unsteady walking/wobbly	☐YES ☐NO
Diabetes	☐YES ☐NO	Muscle twitches/fasciculations	☐YES ☐NO	Falls	☐YES ☐NO
Hot or cold intolerance	☐YES ☐NO	Muscle cramps	☐YES ☐NO	Convulsions/seizures	☐YES ☐NO
Other	☐YES ☐NO	Other	☐YES ☐NO	Fainting/passing out	☐YES ☐NO
CARDIOVASCULAR SYMPTOMS		**PSYCHOLOGICAL SYMPTOMS**		Stroke	☐YES ☐NO
Heart disease	☐YES ☐NO	Anxiety	☐YES ☐NO	Head injury/concussion	☐YES ☐NO
Angina - Chest pain	☐YES ☐NO	Depression	☐YES ☐NO	➥ with loss of consciousness	☐YES ☐NO
Irregular heartbeat	☐YES ☐NO	Hallucinations	☐YES ☐NO	Spinal cord disease	☐YES ☐NO
Other	☐YES ☐NO	Other	☐YES ☐NO	Other	☐YES ☐NO

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Past Medical History

Does the patient have a history of any of the following:

Hypertension	☐ YES ☐ NO	**Blood disorder**	☐ YES ☐ NO
Liver disease	☐ YES ☐ NO	**Bladder problems**	☐ YES ☐ NO
Kidney disease	☐ YES ☐ NO	**Bowel problems**	☐ YES ☐ NO
Seizure disorder	☐ YES ☐ NO	**Multiple sclerosis**	☐ YES ☐ NO
Parkinson's disease	☐ YES ☐ NO	**Vision loss/double vision**	☐ YES ☐ NO
Autoimmune disease	☐ YES ☐ NO	**Memory loss**	☐ YES ☐ NO
Psychiatric disorder	☐ YES ☐ NO	**Cancer**	☐ YES ☐ NO
Gallbladder disease	☐ YES ☐ NO	**Arthritis**	☐ YES ☐ NO
Endocrine disease	☐ YES ☐ NO	**Gynecologic problems**	☐ YES ☐ NO
Diabetes Mellitus	☐ YES ☐ NO	☐ Type 1 ☐ Type 2	
Heart disease	☐ YES ☐ NO	☐ Coronary artery disease/Angina ☐ Heart attack ☐ Atrial fibrillation	
Thyroid disease	☐ YES ☐ NO	☐ Hyper- ☐ Hypo- ☐ Hashimoto's	
Gastrointestinal disorder	☐ YES ☐ NO	☐ GI Bleed ☐ Reflux/GERD ☐ Bowel problems	
Lung disease	☐ YES ☐ NO	☐ Asthma ☐ COPD	
Sleep disturbances	☐ YES ☐ NO	☐ Sleep apnea ☐ Narcolepsy ☐ Insomnia	
Headaches	☐ YES ☐ NO	☐ Migraines ☐ Other Headache	
Muscle disease	☐ YES ☐ NO	☐ Myasthenia gravis ☐ Fibromyalgia	
Stroke/TIA	☐ YES ☐ NO	☐ Carotid disease/stenosis ☐ Intracranial hemorrhage	
Nerve disease	☐ YES ☐ NO	☐ Neuropathy ☐ Nerve pain ☐ Sciatica	
Radiculopathy	☐ YES ☐ NO	☐ Cervical ☐ Lumbar ☐ Thoracic	
Surgery	☐ YES ☐ NO	List:	

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Family Medical History

Please list any family history pertaining to your parents and siblings:

Hypertension	☐ YES ☐ NO	**Diabetes**	☐ YES ☐ NO
Heart disease	☐ YES ☐ NO	**Stroke**	☐ YES ☐ NO
Cancer	☐ YES ☐ NO	**Memory Loss**	☐ YES ☐ NO
Gastrointestinal disorder	☐ YES ☐ NO	**Multiple Sclerosis**	☐ YES ☐ NO
Liver disease	☐ YES ☐ NO	**Autoimmune disease**	☐ YES ☐ NO
Kidney disease	☐ YES ☐ NO	**Thyroid disease**	☐ YES ☐ NO
Lung disease	☐ YES ☐ NO	**Parkinson's disease**	☐ YES ☐ NO
Seizures	☐ YES ☐ NO	**Headaches/Migraines**	☐ YES ☐ NO
Eye disease	☐ YES ☐ NO	**Nerve disease**	☐ YES ☐ NO
Sleep disorder	☐ YES ☐ NO	**Muscle disease**	☐ YES ☐ NO
Other Illnesses	If yes, please list: _____ _____ _____ _____		
☐ **My family history is unobtainable due to being adopted**			
☐ **My family history is unknown**			

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Social History

Are you:

- ☐ Right-handed
- ☐ Left-handed

Do you drink or use caffeine?

- ☐ Yes
- ☐ No

Do you use tobacco products?

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown

Do you drink Alcohol?

- ☐ Yes, socially
- ☐ Yes, 2 or fewer drinks a day
- ☐ Yes, 2 or more drinks a day
- ☐ No

What are your exercise habits?

- ☐ Good exercise habits (more than 3 days a week)
- ☐ Poor exercise habits

What is your occupational status?

- ☐ Full-time as a(n) _____
- ☐ Part-time as a(n) _____
- ☐ Homemaker
- ☐ Currently on disability
- ☐ Unemployed
- ☐ Retired
- ☐ Student
- ☐ Military Service

What is your marital status?

- ☐ Currently Married
- ☐ Domestic Partner
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

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NOTICE OF PRIVACY PRACTICES

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.

For questions about this notice, please contact the Privacy Officer at (703) 876-0800, or at Neurology Center of Fairfax, Ltd., 3020 Hamaker Ct., Ste. 400, Fairfax, VA 22031.

WHO WILL FOLLOW THIS NOTICE.

This notice describes the practices of Neurology Center of Fairfax, Ltd. ("NCF"), its physicians, employees, staff and other personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health (PHI), including genetic information, is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at NCF. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated for services at NCF.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you;
- to notify affected individuals of any breach of unsecured protected health information; and
- follow the terms of this notice in effect and subject to be changed at any time.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and/or try to give some examples. Not every use or disclosure in a category will be listed.

➢➢ **For Treatment**. We may use medical information about you to provide you with medical treatment or services without your individual specific written authorization. We may disclose medical information about you to physicians, nurses, technicians, or other NCF personnel and others outside of NCF who are involved in taking care of you. For example, a physician treating you for another condition may need to know what medications we have prescribed for you. Different individuals at NCF may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and similar care. We may make a professional judgment to determine whether it is in your best interest to disclose medical information about you to people outside NCF who may be involved in your medical care, such as other physicians, or family members involved in your treatment or others.

➢➢ **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at NCF may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about care you received at NCF so your health plan will pay us or reimburse you for the care. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

➢➢ **For Health Care Operations**. We may use and disclose medical information about you for NCF health care operations. These uses and disclosures are necessary to run NCF and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many NCF patients to decide what additional services NCF should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, and technicians and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer.

➢➢ **Business Associates**. We are permitted by law to utilize Business Associates to carry out treatment, payment, health care operations, and business functions that may involve creating, receiving, or transmitting information and disclosure of some of your health information. For example, we may use a billing service or accounting service or some other non-NCF employee arrangement to handle some billing and payment functions. We may also use health care consultants to assist us in improving or upgrading services we offer to patients. However, in any such instance, unless the disclosure of health information is to another health care provider for the purpose of providing treatment to you, we will have entered into a formal Agreement with the Business Associate that requires the Business Associate to maintain the confidentiality of any patient information received and generally requires the Business Associate to limit its use of such information to only the purpose for which it was disclosed by us.

➢➢ **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at NCF.

➢➢ **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

➢➢ **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

➢➢ **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also use and disclose information about you to notify, or to assist in notifying, a family member or friend of your location or condition, but except in emergency circumstances, you will generally be given an opportunity to object.

➢➢ **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Where consistent with the research goals and purposes, we will use or disclose only de-identified information, so that your identity cannot be ascertained from the information disclosed. When research cannot be conducted with such de-identified information, we will usually ask for your specific authorization for such use or disclosure. However, some research projects that involve information gathering may be adversely affected by requiring prior patient authorization before otherwise confidential information can be used or disclosed for research purposes. In those circumstances, research projects are subject to a specific and comprehensive approval process. This process evaluates the proposed research project and its use of medical information, trying to balance research needs with patients' rights to privacy of medical information. Before we use or disclose medical information for research under such circumstances, the project will have been approved by an Institutional Review Board (IRB) or a specially designated privacy board, which will be required to determine whether the nature of the research is such that it could not be conducted if prior patient authorization was required and will be required to determine that adequate protections are in place to protect patient information from unauthorized use or disclosure. However, as part of the research process we may disclose medical information about you to individuals preparing to conduct the research project, for example, to help them look for patients with specific medical needs, but any such medical information will not be allowed to leave our offices.

➢➢ **As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

➢➢ **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person, consistent with applicable law. Any disclosure, however, would only be to someone able to help prevent or lessen the threat.

SPECIAL SITUATIONS

➢➢ **Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

➢➢ **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

➢➢ **Workers' Compensation**. Where required or permitted by state law, we may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

➢➢ **Public Health Risks**. Where required or permitted by state and federal law, we may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

➢➢ **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, investigations, audits, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

➢➢ **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

➢➢ **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our offices; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➢➢ **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of NCF to funeral directors as necessary to carry out their duties.

➢➢ **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

➢➢ **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or for the conduct of special investigations.

➢➢ **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

➢➢ **Right to Inspect and Copy**. You have the right to inspect and obtain copies, or get electronic copies, of your medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, which are notes separate from the medical record made during individual or group counseling. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge for labor, supplies, and postage. Virginia law allows 30 days, with a 30-day extension if justified, to provide you with a copy of your medical record, in the format in which you request it, if reasonably possible.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

➢➢ **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for NCF. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for NCF;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

➢➢ **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. In most cases, this list will not include disclosures made for purposes of treatment, payment, or health care operations, or that were made in response to a specific authorization from you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for the request (i.e. the period covered by the accounting) which may not be longer than six years prior to the date of the request. The first list you request within a 12 month period will be free. For additional accountings, there will be a charge.

➢➢ **Right to Request Restrictions**. 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 use or disclose information about a surgery you had. We are not required to agree to your request, other than a request that we not disclose information to a health plan for payment or health care operations where the request is not required by law and relates only to a health care item or service for which you or a person other than the health plan has paid in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

➢➢ **Right to 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 can ask that we only contact you at work or by mail. We do not communicate PHI by regular e-mail, but our Patient Portal does support a form of secure e-mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We reserve the right to determine our capability to accommodate your request.

➢➢ **Other Rights and Terms**

- You may opt out of communications regarding subsidized treatments.
- We may not use or disclose your PHI for any marketing communications unless you provide written authorization.
- We may not disclose psychotherapy notes about you unless you provide written authorization for NCF to disclose those notes.
- We may not sell your PHI unless you provide written authorization for NCF to do so.

➢➢ **Right to 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 are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at our offices. The notice will contain on the first page, in the top right-hand corner, the effective date. You may also obtain a copy of any current notice by submitting a written request to the Privacy Officer at the address set forth above.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with NCF or with the Secretary of the Department of Health and Human Services. To file a complaint with NCF, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. You will not be penalized or subject to retaliation for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us with authorization to use or disclose medical information about you, you may revoke that authority, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made in reliance upon your prior authorization, and that we are required to retain our records of the care that we provided to you.