

Ivan Aksentjevich, M.D.  
Roy A. Beveridge, M.D.  
Thomas P. Butler, M.D., F.A.C.P.  
Robert J. Christie, M.D., F.A.C.P.  
Ajay Dar, M.D.  
Neelima Denduluri, M.D.  
David M. Dunning, M.D.  
Anne M. Favret, M.D.  
Peter S. Francis, M.D.  
Amy J. Irwin, M.D.  
Arthur N. Kales, M.D.  
Daniel Katcher, M.D.  
Alisan G. Kula, M.D.  
Jey A. Maran, M.D.  
Robert L. Marsh, M.D.  
Robert J. Meister, M.D.  
Gregory J. Orloff, M.D.  
Dipti Patel, M.D.  
Robert L. Reid, M.D., F.A.C.P.  
Nicholas J. Robert, M.D.  
Patriciat A. Rodriguez, M.D.  
Alex I. Spira, M.D.  
Winston M. Ueno, M.D.  
Kerim L. Mokarem, CFNP  
Maureen E. Ross, M.S.N., M.P.H.

Alexandria Office  
4660 Kenmore Ave.  
Suite 1018  
Alexandria, VA 22304  
(P) (703) 823-5322  
(F) (703) 823-5723

Arlington Office  
1635 N. George Mason Dr.  
Suite 170  
Arlington, VA 22205  
(P) (703) 528-7303  
(F) (703) 528-0338

Fair Oaks Office  
3650 Joseph Siewick Dr.  
Suite 200  
Fairfax, VA 22033  
(P) (703) 391-5874  
(F) (703) 391-2607

Fairfax Office  
8503 Arlington Blvd.  
Suite 400  
Fairfax, VA 22031  
(P) (703) 280-5390  
(F) (703) 280-9596

Gainesville Office  
7901 Lake Manassas Dr.  
Gainesville, VA 20155  
(P) (703) 369-1400  
(F) (703) 361-5561

Loudoun Office  
44035 Riverside Parkway  
Suite 300  
Leesburg, VA 20176  
(P) (703) 554-6800  
(F) (703) 724-7503

Woodbridge Office  
2280 Opitz Blvd.  
Suite 300  
Woodbridge, VA 22191  
(P) (703) 897-5358  
(F) (703) 897-7938

Dear Patient:

Thank you for choosing Fairfax Northern Virginia Hematology Oncology (FNVHO). As a new patient to our practice, we encourage you to read through the literature provided in this packet to familiarize yourself with your physician and the practice.

At your first appointment, you will be asked to return a completed copy of the included forms,

1. Assignment of Benefits
2. Medical History
3. HIPPA Practices and Release
4. Patient Request for Health Information

Please also bring with you,

1. All medical insurance cards
2. Insurance Referral from your Primary Care Physician
3. A copy of your medical records (The records we are looking for include: most recent labs, physician notes, radiology, and pathology reports pertinent to your diagnosis.)

Again, thank you for choosing FNVHO for your care and we look forward to meeting and serving you. Should you have any questions regarding this appointment or about us, please feel free to contact us at the office your appointment is scheduled at.

Sincerely,

Fairfax-Northern Virginia Hematology Oncology, P.C.

# Fairfax-Northern Virginia Hematology-Oncology, P.C.

## Arlington Fairfax Hematology Oncology

### ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

Patient Name: \_\_\_\_\_  
Last First M.I. Today's Date  
 ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Telephone Cell Phone

Home Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
Street Street  
 \_\_\_\_\_  
City State Zip City State Zip

DOB: \_\_\_\_\_ Age \_\_\_\_\_  M  F SS# \_\_\_\_\_  Married  Single  Divorced  Widowed  Other  
Sex Check Marital Status

Employer: \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Telephone  
 \_\_\_\_\_  
Address Occupation

Responsible Party: \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Relationship Telephone

Emergency Contact: \_\_\_\_\_  
 Spouse/Next of Kin: \_\_\_\_\_ ( ) \_\_\_\_\_  
Name Relationship Telephone

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Primary Ins:** \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Subscriber Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Secondary Ins:** \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Subscriber Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to Fairfax-Northern Virginia Hematology-Oncology, P.C. (FNVHO)/Arlington-Fairfax Hematology-Oncology (AFHO). I also authorize agents of any hospital, treatment center or previous physician to furnish FNVHO/AFHO copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or report related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within FNVHO/AFHO.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to FNVHO/AFHO. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to FNVHO/AFHO.
4. I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payors; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, the National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplant services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefit plan; (f) persons conducting quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with US Oncology.

**THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.**

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

\_\_\_\_\_  
 Patient Signature Date/Time AM or PM (circle one)

\_\_\_\_\_  
 Responsible Party Signature Relationship Date/Time AM or PM (circle one)

PHYSICIAN: _____	EMPLOYEE INITIALS _____
ACCT NBR: _____	LOC: _____
FOR OFFICE USE ONLY	

**NAME:**

**HEIGHT:**

**REFERRED BY:**

**WEIGHT:**

**MARITAL STATUS:**

**AGE:**

**I. PAST HISTORY**

Please list any surgeries, with dates:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Please list any serious illnesses, with dates:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

List any allergies and/or types of adverse drug reactions:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Have you ever had a blood transfusion: \_\_\_\_\_ If yes, when? \_\_\_\_\_

Have you traveled outside of the U.S. in the last 3 years? \_\_\_\_\_

If yes, what countries? \_\_\_\_\_

Women, please fill out the additional details:

Date of last menstrual cycle: \_\_\_\_\_

Date of last pelvic exam: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_

**II. SOCIAL AND ENVIRONMENTAL REVIEW:**

Occupations: \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ Number of years? \_\_\_\_\_

Do you drink coffee? \_\_\_\_\_ How much? \_\_\_\_\_ Number of years? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_ Number of years? \_\_\_\_\_

Do you use aspirin? \_\_\_\_\_ How much? \_\_\_\_\_ Number of years? \_\_\_\_\_

**III. FAMILY HISTORY:**

Please list any illnesses which run in your family, such as cancer, anemia, leukemia, blood clotting problems or other illnesses.

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Please give the ages and illnesses of the following:

	<b>Living</b>	<b>Deceased</b>
<b>Mother:</b> _____	_____	_____
<b>Father:</b> _____	_____	_____
<b>Brothers:</b> _____	_____	_____
<b>Sisters:</b> _____	_____	_____
<b>Children:</b> _____	_____	_____

**IV. REVIEW OF SYSTEMS:**

Please read the following list of symptoms and *circle all that apply to you.*

<p><b><u>Pain</u></b> Rate the amount of pain you are in – 0 being none, 10 being the worst pain</p>	0	1	2	3	4	5	6	7	8	9	10
<b><u>Constitutional</u></b>	Weight Loss		Fever		Chills		Night Sweats				
	Poor Energy Levels										
<b><u>Eyes</u></b>	Double Vision		Transient/Perm Loss of Vision		Flashing Lights						
<b><u>ENT/Mouth</u></b>	Ringing in ears		Hearing loss		Nose Bleeds		Hoarseness				
	Oral Ulcers		Bleeding Gums		Sore Throat		Sinus Pain				
	Nasal Drip		Mouth Pain		Difficult Swallowing						
<b><u>Cardiovascular</u></b>	Chest Pain		Palpitations		Fainting Spells		Arm Swelling				
	Leg Swelling		Calf Discomfort								
<b><u>Respiratory</u></b>	Cough		Shortness of Breath		Coughing Blood		Pain with Breathing				
	Wheezing										

#### IV. REVIEW OF SYSTEMS (con't)

<b><u>Breast</u></b>	Mass Change in shape	Pain	Nipple Discharge	Change in size
<b><u>Gastrointestinal</u></b>	Nausea Maroon/Black Stool Stomach pain	Vomiting Constipation Vomiting Blood	Jaundice Abdominal Cramping Difficulty Swallowing	Abdominal Pain Diarrhea
<b><u>Urinary</u></b>	Painful Urination	Blood in urine	Increased frequency at night	Loss of control of urine
<b><u>Gynecological</u></b>	Vaginal discharge	Pelvic Pain	Abnormal vaginal bleeding	
<b><u>Musculoskeletal</u></b>	Muscle Pain Spine tenderness	Swollen joints	Joint redness	Bone pain
<b><u>Skin</u></b>	Rash	Nodules	Itchiness	Lesions
<b><u>Neurological</u></b>	Confusion Speech Change Weakness	Seizures Headache Sensory Changes	Fainting Spells Hiccups	Tremors Abnormal Gait
<b><u>Psychiatric</u></b>	Depression	Anxiety	Lack of Concentration	
<b><u>Endocrine</u></b>	Excessive Urine	Excessive Thirst	Hot Flashes	Heat or Cold Tolerance
<b><u>Hematological</u></b>	Nose Bleeds	Bleeding Gums	Purple Spots on Hands	Bruising
<b><u>Lymphatic</u></b>	Enlarged lymph nodes	Swelling in the arms		
<b><u>Allergy/Immunological</u></b>	Hives/Allergic Reactions	Recurrent hives	Frequent infections (respiratory or skin)	

**V. REFERRING PHYSICIANS:**

Please list all referring physicians and those physicians you are currently seeing.

Doctor	Address	Phone Number
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

**VI. MEDICATIONS**

Please list all medications that you are currently taking.

1.	_____
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____

**VII. PHARMACY**

Please list your pharmacy information.

Pharmacy	Address	Phone Number
1.	_____	_____

Patient Signature: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **RIGHTS AND RESPONSIBILITIES OF PATIENTS**

**As a Patient, I have the RIGHT to:**

- 1. Full information of my rights and responsibilities as a patient of Fairfax-Northern Virginia Hematology-Oncology, P.C. (FNVHO).**
- 2. Receive and explanation of my diagnosis, benefits of treatment, alternative, recuperation, right and an explanation of consequences if treatment is not pursued.**
- 3. An explanation of all services provided by FNVHO, the days and hours of service and provisions for possible emergency care, including telephone numbers;**
- 4. Participate in development of a plan of treatment.**
- 5. Make known Advance Directives or a Living Will, if I wish;**
- 6. Refuse participation in any protocol or aspect of care including investigational studies, and freely withdraw my previous given consent for further treatment;**
- 7. Disclosure of any teaching programs, research or experimental programs in which the facility is participating;**
- 8. Full financial explanation and payment schedule prior to beginning treatment;**
- 9. Receive professional care without discrimination, regardless of race, creed, color religion, national origin, sexual preference, handicap, sex or age;**
- 10. Be treated with courtesy, dignity and respect of my personal privacy by all employees of FNVHO;**
- 11. Be free of physical/mental abuse and/or neglect by all employees of FNVHO;**
- 12. Complain or file grievances with representatives of FNVHO without fear of retaliation or discrimination;**
- 13. Confidential treatment of my condition, medical record and financial information.**
- 14. Access to my personal records and obtain copies upon written request.**

**As a PATIENT, I have the RESPONSIBILITY to:**

- 1. Disclose accurate and complete information related to physical condition, hospitalizations, medications, allergies, medical history and related items.**
- 2. Assist in maintaining a safe, peaceful and efficient ambulatory environment;**

- 3. Provide new/changed information related to my health insurance to the business office and be prepared to meet my agreed co-pay during my office visit.**
- 4. Contact the office when unable to keep a scheduled appointment;**
- 5. Cooperate in the planned care and treatment developed for me;**
- 6. Request more detailed explanations for any aspect of service I don't understand;**
- 7. Inform my physicians and nurses of any changes in my condition or any new problems or concerns;**
- 8. Communicate any temporary or permanent change in my address or telephone number which might hinder contact by the office staff.**

Effective Date: April 14, 2003

## 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.

### **About Us**

In this Notice, we use terms like “we,” “us” or “our” to refer to Fairfax-Northern Virginia Hematology-Oncology, P.C., its physicians, employees, staff and other personnel. All of the sites and locations of Fairfax-Northern Virginia Hematology-Oncology, P.C. follow the terms of this Notice and may share health information with each other for treatment, payment or health care operations purposes as described in this Notice.

### **Purpose of this Notice**

This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We need to maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately.

### **Our Responsibilities**

We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of this Notice.

### **How We May Use or Disclose Your Health Information**

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

For Treatment: We may use your health information to provide you with medical treatment or services. For example, your health information will be disclosed to the oncology nurses who participate in your care. We may disclose your health information to another oncologist for the purpose of a consultation. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

For Payment: We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

For Health Care Operations: We may use and disclose your health information in order to support our business activities. For example, we may use your health information for quality assessment activities, training of medical students, necessary credentialing, and for other essential activities.

We may ask you to sign your name to a sign-in sheet at the registration desk and we may call your name in the waiting room when we call you for your appointment.

We may disclose your health information to a third party that performs services, such as billing and collection, on our behalf. In these cases, we will enter into a written agreement with the third party to ensure they protect the privacy of your health information.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify the “Privacy Official” in writing at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031.**

We may also disclose your health information to disaster-relief organizations so that your family can be notified about your condition, status and location.

We are also allowed by law to use and disclose your health information without your authorization for the following purposes:

As Required by Law: We may use and disclose your health information when required to do so by federal, state or local law.

Judicial and Administrative Proceedings: If you are involved in a legal proceeding, we may disclose your health information in response to a court or administrative order. We may also release your health information 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.

Health Oversight Activities: We may use and disclose your health information to health oversight agencies for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government benefit programs, compliance with government regulatory programs, and compliance with civil rights laws.

Law Enforcement: We may disclose your health information, within limitations, to law enforcement officials for several different purposes:

- To comply with a court order, warrant, subpoena, summons, or other similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime, if unable to obtain the victim's agreement;
- About a death we suspect may have resulted from criminal conduct;
- About criminal conduct we believe in good faith to have occurred on our premises; and
- To report a crime, the location of a crime, and the identity, description and location of the individual who committed the crime, in an emergency situation.

Public Health Activities: We may use and disclose your health information for public health activities, including the following:

- To prevent or control disease, injury, or disability;
- To report births or deaths;
- To report child abuse or neglect;
- To report adult abuse or neglect;
- To report adverse events, product defects or problems;
- To track FDA-regulated products;
- To notify people and enable product recalls; and
- To notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition.

Serious Threat to Health or Safety: If there is a serious threat to your health and safety or the health and safety of the public or another person, we may use and disclose your health information to someone able to help prevent the threat.

Organ/Tissue Donation: If you are an organ donor, we may use and disclose your health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank.

Coroners, Medical Examiners, and Funeral Directors: We may use and disclose health information to a coroner or medical examiner. This disclosure may be necessary to identify a deceased person or determine the cause of death. We may also disclose health information, as necessary, to funeral directors to assist them in performing their duties.

Workers' Compensation: We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose health information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence as required or authorized by law.

Military and Veterans Activities: If you are a member of the Armed Forces, we may disclose your health information to military command authorities. Health information about foreign military personnel may be disclosed to foreign military authorities.

National Security and Intelligence Activities: We may disclose your health information 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 your health information to authorized federal officials so they may provide protective services for the President and others, including foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official to assist them in providing you health care, protecting your health and safety or the health and safety of others, or for the safety of the correctional institution.

Research: We may use and disclose your health information for certain limited research purposes. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project, assesses a number of specific issues, and determines that appropriate privacy safeguards are in place to allow the use of health information in the research project. We may, however, disclose your health information to people preparing to conduct a research project; for example, to help them look for patients with specific medical needs, so long as the health information they review does not leave the practice.

Other Uses and Disclosures of Your Health Information: Other uses and disclosures of your health information not covered by this Notice or the laws that apply to us will be made only with your authorization. If you authorize us to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information as specified by the revoked authorization, except to the extent that we have taken action in reliance on your authorization.

### **Your Rights Regarding Your Health Information**

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

Right to Request Restrictions: You have the right to request restrictions on how we use and disclose your health information for treatment, payment or health care operations. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or as otherwise required by law. To request restrictions, you must make your request in writing and submit it to the “Privacy Official” at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031.

Right to Request Confidential Communications: You have the right to request that we communicate with you in a certain manner or at a certain location regarding the services you receive from us. For example, you may ask that we only contact you at work or only by mail. To request confidential communications, you must make your request in writing and submit it to the “Privacy Official” at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031. We will not ask you the reason for your request. We will attempt to accommodate all reasonable requests.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. To inspect and copy your health information, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the “Privacy Official” at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031. If you request a copy of your health information, we may charge a fee for the costs of copying, mailing or preparing the requested documents.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed by a licensed health care professional chosen by us. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that your health information is incorrect or incomplete, you may request that we amend your information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the “Privacy Official” at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031.

We may deny your request for an amendment. If this occurs, you will be notified of the reason for the denial and given the opportunity to file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures we make of your health information. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provide to you.

To request an accounting of disclosures, you must make your request in writing by filling out the appropriate form provided by us and submitting it to the “Privacy Official” at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at any time, even if you previously agreed to receive this Notice electronically. To obtain a paper copy of this Notice, please contact the “Privacy Official” at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031.

Right to Complain: If you have any questions about this Notice or would like to file a complaint about our privacy practices, please direct your inquiries to: the “Privacy Official” at Fairfax-Northern Virginia Hematology-Oncology, P.C. 8503 Arlington Blvd, Suite 400, Fairfax, Virginia 22031. You may also file a complaint with the Secretary of the Department of Health and Human Services. **You will not be retaliated against or penalized for filing a complaint.**

## **Changes to this Notice**

We reserve the right to change the terms of this Notice at any time. We reserve the right to make the new Notice provisions effective for all health information we currently maintain, as well as any health information we receive in the future. If we make material or important changes to our privacy practices, we will promptly revise our Notice. We will post a copy of the current Notice in the waiting room of each office. Each version of the Notice will have an effective date listed on the first page.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Fairfax-Northern Virginia Hematology-Oncology, P.C. is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Fairfax-Northern Virginia Hematology-Oncology, P.C.

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Name of Personal Representative (if appropriate):** \_\_\_\_\_

**Signature of Personal Representative (if appropriate):** \_\_\_\_\_

**Date:** \_\_\_\_\_

---

Fairfax-Northern Virginia Hematology-Oncology, P.C. Use Only

Date acknowledgement received: \_\_\_\_\_

**-OR-**

**Reason acknowledgement was not obtained and employee signature:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fairfax-Northern Virginia Hematology-Oncology, P.C.

Patient Request for Health Information Copies at Time of Visit
Routine, Ongoing Disclosure

Please complete this form if you would like routine copies of your labs or other protected health information when you come for your appointment. Completion of the form is totally voluntary. If you do not complete this form and you want a copy of your lab report, we will ask you to complete a "Health Information Access Request Form" each time you want one. The State of Virginia has decreed that medical records are the property of the practice rather than the individual. We encourage you to know about your health and associated health information.

Please indicate, specifically, the information to which you are requesting access:

Routine labs and other protected health information not subject to denial.

Please indicate the form or format in which you would like to receive your requested information:

Photocopy

Please indicate the means by which you wish to inspect or obtain a copy of the requested information (fax, mail, on-site, etc.), and provide the necessary phone number or address:

On site

I authorize Fairfax-Northern Virginia Hematology-Oncology, P.C. to use and disclose my health information in the manner described above. I understand that I am responsible for protecting the privacy of the information once I receive it. This authorization will be in effect until I revoke it. I understand that I may revoke this authorization at any time by notifying Fairfax-Northern Virginia Hematology-Oncology, P.C. in writing.

Patient Name

Date of Birth

Signature

Date

Name of Personal Representative (if appropriate)

Signature of Personal Representative (if appropriate)

For Fairfax-Northern Virginia Hematology-Oncology, P.C. Use Only:

Date Received: Accepted Denied

If denied, check reason for denial:

Excepted Information Inmate Request Confidentiality Issues
Research Privacy Laws Other:

Date and method of informing individual of original decision:

If denied, was review requested? Yes No

Name of reviewing official: Decision on review:

Date and method of informing individual of review decision:

Comments:

Staff Member Signature

Date