AARC

Advanced Arthritis & Rheumatology Care, P.C.

Shikha Sarebahi, MD

14360 Sommerville Ct, Midlothian, VA 23113

Phone : (804) 639-7850 Fax: (804) 806-5988

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.

Marital status (circle one)

Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No

If not, what is your legal name? (Former name):

Birth date: / /

Age:

Sex: ❑ M ❑ F

Street address:

Social Security no.:

Home phone no.: ( )

P.O. box:

City:

State:

ZIP Code:

Occupation:

Employer:

Employer phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Email:

Advanced Directive

❑ Yes, if yes please list full name and relationship :

❑ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):

Relationship to patient:

Home phone no.: ( )

Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

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RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time, have you or a blood relative had any of the following? (check if "yes")

Yourself	Disease	Relationship	Yourself	Disease	Relationship
☐	Arthritis		☐	Lupus/SLE	
☐	Osteoarthritis		☐	Rheumatoid Arthritis	
☐	Gout		☐	AnkylosingSpondylitis	
☐	Childhood Arthritis		☐	Osteoporosis	
Other					

Pertinent Tests: Date of last exams:

Mammogram_____ Eye _____Chest x–ray _____

Tuberculosis Test _____ Bone density Scan _____

SOCIAL HISTORY

Do you drink caffeinated beverages?_____

Cups/glasses per day?_____

Do you smoke? ☐ Yes ☐ No

How long ago?__ How much?_____

Do you drink alcohol? ☐ Yes ☐ No

Number per week_____

Has anyone ever told you to cut down on your drinking?

☐ Yes ☐ No

Do you use drugs for reasons that are not medical?

☐ Yes ☐ No

If yes, please list

_____

_____

_____

PAST MEDICAL HISTORY

Do you now or have you ever had: *(check if "yes")*

☐ Cancer	☐ Heart problems	☐ Leukemia
☐ Asthma	☐ Stroke	☐ Cataracts
☐ Goiter	☐ Diabetes	☐ Epilepsy
☐ Bad headaches	☐ Stomach ulcers	☐ Kidney disease
☐ Colitis	☐ Pneumonia	☐ Psoriasis
☐ Anemia	☐ HIV/AIDS	☐ Emphysema
☐ Tuberculosis	☐ Glaucoma	☐ Jaundice
☐ High Blood Pressure	☐ Nervous breakdown	☐ Rheumatic fever

Other significant illness (please list):_____

_____

Natural or Alternative Therapies (Chiropracty, Magnets, Massage, over-the-counter preparations, etc.):

_____

_____

#	Previous Operations	Year	Reason
1			
2			
3			
4			
5			
6			
7			
8			

Any previous fractures? ☐ No ☐ Yes Describe:_____

Any other serious injuries? ☐ No ☐ Yes Describe:_____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer	☐ Leukemia	☐ Heart disease	☐ Epilepsy
☐ Tuberculosis	☐ Diabetes	☐ Stroke	☐ Colitis
☐ Alcoholism	☐ Asthma	☐ Psoriasis	☐ Bleeding tendency
☐ High blood pressure	☐ Rheumatic fever		

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	Name of Drug	Dose (include strength & number of pills per day)	Length of Time?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken and list any ***reactions*** you may have had.

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

- ☐ Arthrotec
- ☐ Celebrex
- ☐ Aspirin
- ☐ Ansaid
- ☐ Clinoril
- ☐ Daypro
- ☐ Dolobid
- ☐ Feldene
- ☐ Indocin
- ☐ Lodine
- ☐ Meclomen
- ☐ Motrin
- ☐ Naproxen
- ☐ Ketoprofen
- ☐ Tolectin
- ☐ Trilisate
- ☐ Vioxx
- ☐ Voltaren

Pain Relievers

- ☐ Acetaminophen/Codeine
- ☐ Tylenol
- ☐ Propoxyphene
- ☐ Darvon
- ☐ Darvocet
- ☐ Vicodin
- ☐ Tylenol #3

Other: _____

Disease Modifying Antirheumatic Drugs (DMARDS)

- ☐ Auranofin, gold pills (Ridaura)
- ☐ Gold shots (Myochrysine or Solganol)
- ☐ Hydroxychloroquine (Plaquenil)
- ☐ Penicillamine (Cuprimine or Depen)
- ☐ Methotrexate (Rheumatrex)
- ☐ Azathioprine (Imuran)
- ☐ Sulfasalazine (Azulfidine)
- ☐ Quinacrine (Atabrine)
- ☐ Cyclophosphamide (Cytoxan)
- ☐ Cyclosporine A (Sandimmune or Neoral)
- ☐ Etanercept (Enbrel)
- ☐ Infliximab (Remicade)
- ☐ Prosorba Column
- ☐ Humira (Adalimumab)
- ☐ Orencia (Abatacept)
- ☐ Rituxan (Rituximab)

Other Medications

- ☐ Estrogen
- ☐ Alendronate (Fosamax)
- ☐ Raloxifen/ Evista
- ☐ Calcitonin Injection/ nasal (Miacalcin)
- ☐ Residronate (Actonel)
- ☐ Probenecid
- ☐ Colchicine
- ☐ Allopurinol
- ☐ Prednisone
- ☐ Hyalgan/ Synvisc

Drug allergies: ☐ No ☐ Yes To what? _____

Type of reaction _____

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CONSENT TO TREAT FORM

I, _____ , do hereby give consent to AARC P.C. to

Perform any as needed procedures by Dr. Shikha Sarebahi MD. I also authorize payment of medical benefits to AARC P.C. for services rendered by Dr. Shikha Sarebahi MD.

Participant's Signature: _____

Date Signed: _____

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Consent for Non-Face-to-face "Virtual" Visits

Patient Name: _____ Date of Birth: _____

Date: _____

I, _____ hereby voluntarily consent to receive "virtual" care.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at _____ _____.

"Virtual Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the Provider. _____ (initials)
- I understand that my voice and image may be recorded in order to assist in my treatment and I consent to any such audio and video recording. _____ (initials)
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation. _____ (initials)
- I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care. _____ (initials)
- I understand that standard deductible and coinsurance amounts apply to these "Virtual Visits" and I consent to Virtual Treatment _____ (initials)

This form has been explained to me and I fully understand this *Consent for* **Non-Face-to-face "Virtual" Visits** and agree to its contents.

Signature of Patient or Person Authorized to consent for patient:

_____ _____
Name Date

HAQ-II (Health Assessment Questionnaire-II)

http:// Rheuminfo.com
your rheumatology resource

We are interested in learning how your illness affects your ability to function in daily life. Place an X in the box which best describes your usual abilities **OVER THE PAST WEEK**. *Are you able to:*

Name: Date:	Without any difficulty (0)	With some difficulty (1)	With much difficulty (2)	Unable (3)
Get on and off the toilet?	☐	☐	☐	☐
Open car doors?	☐	☐	☐	☐
Stand up from a straight chair?	☐	☐	☐	☐
Walk outdoors on flat ground?	☐	☐	☐	☐
Wait in a line for 15 minutes?	☐	☐	☐	☐
Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Go up 2 or more flights of stairs?	☐	☐	☐	☐
Do outside work (such as yard work)?	☐	☐	☐	☐
Lift heavy objects?	☐	☐	☐	☐
Move heavy objects?	☐	☐	☐	☐

How much **PAIN** have you had because of your illness in the **PAST WEEK**?

No Pain ☐(0) ☐(1) ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Very Severe Pain

How much of a **PROBLEM** has **UNUSUAL FATIGUE or TIREDNESS** been for you **OVER THE PAST WEEK**?

Fatigue is no Problem ☐(0) ☐(1) ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Fatigue is a Severe Problem

How much of a **PROBLEM** has **SLEEPING** been for you **OVER THE PAST WEEK**?

Sleep is no problem ☐(0) ☐(1) ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Sleep is a Severe Problem

How **ACTIVE** has your **ARTHRITIS** been in the **LAST 24 HOURS**?

Not Active ☐(0) ☐(1) ☐(2) ☐(3) ☐(4) ☐(5) ☐(6) ☐(7) ☐(8) ☐(9) ☐(10) Very Active

When you get up in the **MORNING** do you feel **STIFF**? ☐ YES ☐ NO

If you answer YES, please write the number of minutes: _____, OR number of hours:_____
until you are as limber as you will be for the day?

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HIPAA ACKNOWLEDGEMENT AND PATIENT PREFERENCES

HIPAA (The Health Insurance Portability and Accountability Act) provides protection to patients intended to limit the disclosure of protected health information (PHI). PHI is any data concerning your treatment in the office. We make every effort to comply completely with these HIPAA privacy regulations. At the same time, we do not want our patients to be inconvenienced when they wish to have a spouse or family member call us for test results of prescriptions from our office when it is inconvenient for you to do so.

Please provide answers to the following questions. Your answers should help us serve you better, while ensuring that your privacy is protected. This information maybe changed by you at any time.

_____ _____

Name of Designee to Receive PHI Relationship to Patient

_____

Name of Designee to Receive Medical Records Only

I the undersigned, _____ acknowledge that I have been provided with a copy of Advanced Arthritis and Rheumatology Care, P.C.'s Notice of Privacy Practices and have been given an opportunity to review and ask questions about the notice.

Participant's Signature: _____ **Date Signed:** _____

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RECORDS REQUEST

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information:(records are coming from)

B. Person(s) or Organization(s) authorized to receive the information:

Dr. Shikha Sarebahi, MD
Advance Arthritis and
Rheumatology Care, P.C.
Midlothian, VA. 23112
(Phone)804-639-7850
(Fax)804-806-5988

C. Specific description of the information that may be used or disclosed (including date(s)):

D. Specific description of how the information will be used:

1. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in **A** (above) in writing.
2. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable.
3. I may **inspect or copy** any information used or disclosed under this agreement.
4. I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would **no longer be protected** by these regulations.

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.")*.

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s))*.

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research)*.

You have the right to alter this request. We have preprinted options for your convenience. You may alter these items if needed.

You have the right to receive a copy of this form

Virginia Advance Directive

PRINT YOUR NAME

I, _____,
willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care, as follows in this document.

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

PART I: APPOINTMENT OF AGENT

(CROSS THROUGH AND INITIAL IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY AGENT

I hereby appoint _____,
(primary agent)
of _____

_____
(address and telephone number)

as my agent to make health care decisions on my behalf as authorized in this document. If the person I have appointed above is not reasonably available or is unable or unwilling to act as my agent, then I appoint

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

_____,
(alternate agent)
of _____

_____,
(address and telephone number)
to serve in that capacity.

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

In making health care decisions on my behalf, I want my agent to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my agent cannot determine what health care choice I would have made on my own behalf, then I want my agent to make a choice for me based upon what he or she believes to be in my best interests.

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FINANCIAL DISCLOSURE FORM

Thank you for choosing **Advanced Arthritis and Rheumatology Care, P.C (AARC).** This document outlines our financial policies. Please carefully read and understand this, before signing this document.

Referrals: Some insurances require patients to have a referral from a primary care physician. If a referral is required, no services will be rendered until the referral has been received or the patient pays for the services at the time they are rendered.

Changes in Name/Address/Phone/Insurance Information, etc.: Please note that, ensuring current information at our office, related to name, addresses, phone, insurance, etc., is your responsibility. Please notify of any changes so that we can ensure that everything is in place for your visit (e.g. Referrals, Prior Authorizations, etc.). Any insurance changes need to be communicated to the office at the earliest in order to avoid charges being billed to you. We may ask you to present your insurance card(s) at each visit.
In the event, a new referral/authorization is necessitated due to such changes, we may have to respectfully reschedule your appointment ,if the referral/ authorization cannot be obtained within available time.

Payment in full is due at the time of service for patient's share: Please understand that co-payments, co-insurances, deductible not met, previous account balances are due at the time of check-in and will be collected at the time of service unless payment plan arrangements have been made prior to the visit. If upon arrival for your appointment, you are unable to make your co-payment or for previous balances, payment installment agreed to, you may be asked to reschedule your appointment.

Insurance Claims and Coverage: We will submit a claim to your insurance company as a courtesy to you. However, it is Patient's responsibility to provide accurate insurance information (including primary and/or secondary coverage, subscriber's details, etc.). Failure to provide complete and accurate information may result in patient responsibility for the charges for our services. We will provide an estimate for out of pocket expenses on a best effort basis only, as your insurance company reserves the final right to determination of eligibility and benefits. For out of network patients, payments rendered to them directly by their insurance company needs to be promptly forwarded to us. If your coverage lapses due to non-payment of premiums, you will be responsible for full payment. We reserve the right to verify with your insurance, if your coverage is reinstated after a lapse, before services can be rendered.

Self-pay and out of contract patients – For patients with no insurance/ plans that we do not accept, you will be expected to pay the following at the time of the appointment ($250 – New patient visit, $150 - Follow-up visit. Injections and additional services will be separate).

Cancellation /Missed Appointments: It is very important that you call at least 24 hours in advance to cancel or reschedule your appointment. There will be a No-Show fee for every missed appointment ($40-Doctor/Nurse visit, $60-Infusion/Injections) when you do not provide advance notice of at least 24 hours. Following a second no-show fee incident, you may be subject to discharge from the practice.

Fees for Letters and Forms: This office will fill out forms that you may need or provide documents upon your request (e.g. FMLA, DMV, Disability forms, medical records and doctor notes, etc). Please be advised that there will be a fee ($15 for each form) for this service. Those costs are not covered by the insurance companies.

Returned Checks: For any check returned due to insufficient funds, an additional $35 returned check fee will apply in addition to the original check amount. Following a returned check incident, you will be required to make payments using cash or credit cards only.

Outstanding balances, delinquent accounts and collection fees: Patients are responsible for all outstanding balances on their account. Patients unable or unwilling to pay their balances may also be subject to being discharged from the practice. We will send you three statements for any unpaid balances and for any balances due over 120 days, your account will be referred to collections.

Payment Plans: In the event of financial hardship, we will work with you to create a mutually agreeable payment plan. You may be required to a sign a formal payment plan agreement which will outline all agreed terms. If you fail to meet your obligation after agreeing to a payment plan, you may be subject to being dischargec from the practice.

Authorization

I hereby authorize my insurance benefits to be paid directly to Advanced Arthritis and Rheumatology Care, P.C. and acknowledge that I am financially responsible for any unpaid portion of my bill.

I also acknowledge that I have carefully read this financial policy and I understand and agree to all the terms set in it.

Patient's Signature: _____

Date Signed: _____

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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 OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION : We are committed to protect your personal information. We are required by law to maintain the privacy of Protected Health Information(PHI). PHI includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to PHI.

CHANGES TO THIS NOTICE: We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at any time. We will provide you our revised Notice of Privacy Practices upon request.

PERMITTED USES AND DISCLOSURES: As provided by law, we can use or disclose your PHI for purposes of treatment, payment and health care operations. If you refuse to consent, we do not have to provide you with non-emergency care. Treatment means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health provider to another. For example, your PHI may be provided to a physician who referred you to our practice.

Payment means activities we undertake to obtain reimbursement for the health care provided to you, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide to your insurance company information about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the insurance company for the services rendered to you, we can provide the insurance company with the information regarding your care, if necessary, to obtain payment.

Health Care Operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of our staff when caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of

interest to you. When we determine, in our professional judgment, that it is in your best interest, we may disclose your PHI to your family or friends when they are involved in your care or the payment of your care. We will only disclose the PHI directly relevant to their involvement in your care or payment.

We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, x-rays and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

We will share your PHI with third party "business associates" that perform various activities (e.g., answering service) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

We may use or disclose your protected health insurance information in the following situations without your consent or authorization. These situations include:

- Required By Law: We may use or disclose your PHI to the extent that the law requires the use of disclosure. The use of disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We

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- may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition.
- Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system government benefits programs, other government regulatory programs and civil rights laws.
- Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products to enable product recalls, make repairs or replacements, or to conduct post marketing surveillance as required.

- Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request, or other lawful process.

- Law Enforcement: We may also disclose your PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: 1) legal processes and otherwise required by law, 2) limited information requests for identification and location purposes, 3) pertaining to victims of crime, 4)

suspicion that death has occurred as a result of criminal conduct, 5) in the event that a crime occurs on the premises of the practice, and 6) medical emergency (not on Practice's premises) and it is likely that a crime has occurred.

- Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forced personnel: 1) for activities deemed necessary by the appropriate 5military command authorities, 2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, 3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- Except for the general uses and disclosures described above, we will not use or disclose your PHI for any other purposes unless you provide a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS: 1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request. 2. You have the right to reasonably request to receive communications of PHI by alternative means or at alternative locations. 3. You have the right to inspect and copy the PHI contained in your medical and billing records and in any other Practice records used by us to make decisions about you. 4. You have the right to request to receive a paper copy of this notice from us.

COMPLAINTS: If you believe that your privacy rights have been violated, you should immediately contact DR.SHIKHA SAREBAHI. Please be assured that there will be no action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONFIDENTIALITY POLICY STATEMENT: The practice adheres to a strict confidentiality policy for all PHI. PHI is any information that identifies an individual and describes his or her health status, age, sex, ethnicity or demographic characteristics. NOTE:

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Phone : (804) 639-7850 Fax: (804) 806-5988

In accordance with state law, in our practice, confidentiality of HIV-related information is held to a particularly rigorous standard with specific rules and regulations. All references to PHI in this Personnel Policy include confidential HIV-related information.

Internal Communications Rule: Who May Access and Share PHI Within the Office. It is our policy that accessing and sharing PHI by and among employees is limited to "Authorized Employees" only. "Authorized Employees" include these job titles: Physician, Nurse Practitioner, Administrator, Manager, RN, Medical Assistant, Biller, Receptionist

Telephone Clerk, File Clerk. Further, accessing and sharing of PHI is permitted ONLY IF it is in the ordinary course of, and necessary to, the performance of the Authorized Employee's duties and responsibilities in providing, supervising, administering or monitoring health care or maintaining or processing medical records for billing or reimbursement. This is a strict "need-to-know" standard.

Employees of the practice must adhere to all federal and state laws governing and limiting disclosure of PHI.

Confidential Information - In General . As part of our general practice policy THE ABOVE INTERNAL COMMUNICATIONS RULE applies to ALL communications, documents and records in the office (whether written, oral or electronic, and whether patient or business related). ALL such communications, documents and records are confidential and must be

treated accordingly. Security Rules Governing ALL Patient and Business Confidential Information In adherence to our overall general confidentiality policy, these security rules apply:

A. Make all reasonable efforts to maintain all records securely and away from observation by all unauthorized people. For example, do not leave information on a computer screen or in an open chart visible to others; lock doors after hours; and keep all keys, alarm codes and computer passwords secure.

B. Access and share information only when authorized and necessary for the performance of one's duties and responsibilities. This is a strict "need-to-know" standard!

C. Make no disclosure of information except as is necessary for such performance and then only to people authorized by law to have such information. For example, don't leave medical information of any kind on an answering machine; make all reasonable efforts to not share patient information in earshot of unauthorized individuals; do not assume the person asking for information is authorized to get it, no matter how close the relationship to the patient; follow all office policies and procedures regarding disclosure of information.

D. Strict adherence to the law and to the practice's confidentiality policy and procedures is a requirement of employment. Violation of this policy may result in disciplinary action up to and including discharge. E. As a condition of employment, each employee must agree to be bound by the practice's confidentiality policy and procedures during and even after termination of employment.

Participant's Signature: _____ **Date Signed**: _____