



NOTICE OF INFORMATION PRACTICES

1. Virginia Pulmonology and Critical Care LLC may use and disclose protected health information for treatment, payment, and healthcare operations. Treatment examples include, but are not limited to, referrals to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.
2. Virginia Pulmonology and Critical Care LLC is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health uses or court orders.
3. An authorization from the patient is required for uses or disclosures for marketing purposes and for any disclosure constituting the sale of protected health information. No other use or disclosure of a patient's protected health information will be made without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Patients have the right to opt out of any communication involving fundraising. In the event of a breach of unsecured protected health information, a notification will be provided. Virginia Pulmonology and Critical Care LLC will abide by the terms of the notice currently in effect at the time of the disclosure.
5. Virginia Pulmonology and Critical Care LLC reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Virginia Pulmonology and Critical Care LLC will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.
6. Any patient, guardian or personal representative has the right to object to the use of their health information for directory purposes. Additionally, any patient, guardian or personal representative has the right to inspect and obtain their medical record, as well as request amendments be made to their medical record.
7. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.
8. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket; but if the Practice does agree, the Practice must abide by those restrictions.
9. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the address and/or phone number listed above. All complaints will be addressed, and the results will be reported to the Privacy Officer.



V-PaCC

Virginia Pulmonology and Critical Care LLC

4604 Spotsylvania Parkway
Suite 340
Fredericksburg, VA 22408
(540) 200-8272
info@v-pacc.com
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10. It is the policy of Virginia Pulmonology and Critical Care LLC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

Effective date: _____ Name of Patient: _____

Signature of Patient or Legal Guardian: _____ Date: _____

CONSENT FORM

(For Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, or Healthcare Operations (TPO))

I understand that as part of my healthcare, Virginia Pulmonology and Critical Care LLC originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand the Practice reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested other than the exception noted in the **Notice of Information Practices**. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

With this consent, Virginia Pulmonology and Critical Care LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Virginia Pulmonology and Critical Care LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and other correspondence as long as they are marked Personal and Confidential.

With this consent, Virginia Pulmonology and Critical Care LLC may e-mail to me appointment reminders and patient statements. I have the right to request that Virginia Pulmonology and Critical Care LLC restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested



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restrictions except for a request for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket, but if it does, it is bound by this agreement.

By signing this form, I am consenting for Virginia Pulmonology and Critical Care LLC to use and disclose my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Virginia Pulmonology and Critical Care LLC may decline to provide treatment to me.**

Print Patient Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____