Northern Virginia Gastroenterology, P.C.

NISHA CHAND, M.D.
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PATIENT FINANCIAL RESPONSIBILITY

I hereby authorize the physician to apply for benefits on my behalf for covered services rendered. I request payment from my insurance, be paid directly to Northern Virginia Gastroenterology.

I certify that the information I have reported with regards to my insurance coverage is correct. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named below.

I agree to pay **$75 cancellation fee** if I don't provide at least **2 days of notice** of cancellation or re-scheduling.

If for any reason you need to re-schedule or cancel your appointment, you must give 2 days of notice. This fee is patient responsibility and WILL NOT be billed to Insurance.

Physician's Name: _____

Patient's Name: _____

Signature: _____

Date: _____

Northern Virginia Gastroenterology, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED INFORMATION (HIPAA)

Treatment: We may use or disclose information about you for treatment purposes to doctors, nurses, technicians medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals who are outside of our practice, such as consulting physician, laboratories, etc.

Payment: We may use or disclose information about you for operational concerns in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

To a public health agency, for purpose such as controlling disease

In case of suspected child abuse, to the appropriate government authority

In other cases of suspected abuse, neglect or domestic violence, with your agreement: or if you are incapacitated or it appears necessary to prevent serious harm to you or other

To health oversight authorities, for licensing and other legal purposes

In litigation, subject to certain requirements controlling the term of the disclosure

To law enforcement agencies, subject to applicable legal requirements and limitations

Worker's Compensation: In such cases that your treatment is a result of an injury on the job, we may release your information to the appropriate carrier/employer.

To funeral directors, medical examinations, coroners: in the event of your death

When required by Federal, State, or Local law

For medical research purposes, subject to your authorization, unless a waiver of authorization has been granted by an institutional review board or privacy board

If you are in the U.S military, National Security or Intelligence, Foreign Service, to your authorized superiors or other authorized federal officials

We will routinely contact patients via telephone at home, work or cell phone unless otherwise requested, may leave messages on the appropriate voice mail regarding appointments or results. Please advise us if you do not wish to receive such communications, and will not use or disclose your information for such purposes. We may not use or disclose information about you for any other purpose without your written consent.

The Law entitles you to:

Ask us to further restrict our use and disclose of information about you. We are not required to grant such a request, but if we do, we must make sure the restrictions are implemented.
Receive confidential communication from us, at an alternative address you provide to us.

Review our records of your information

Ask us to amend our records, if you believe that they are incorrect or incomplete. We are not required to make such an amendment, if you are entitled to have a statement of our disagreement included in your records. If you do include a statement of disagreement in your records, we may include a statement of explanation or response in your records as well.

Obtain an accounting of all persons to which we have disclosed information about you, for any purpose except your treatment, payment for your treatment, or our health care operations.

If you believe we have violated your privacy rights, you may forward us written complaint to our office address. You may also file a complaint with the Secretary of the United States Department of Health and Human Services. If you file a complaint we are legally prohibited from retaliation against you.

Patient's Name: _____

Patient's Signature: _____ **Date:** _____

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CONSENT FOR TREATMENT AND DISCLOSURE OF HEALTH INFORMATION

You may disclose my health information to the following people or entities.

(spouse, parent, sibling, child, Primary Care Physician or Specialist, Pharmacy, etc)

1. _____
2. _____
3. _____

Patient's Name: _____

Signature: _____

Date: _____

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TELE-MEDICINE CONSENT FOR VIRTUAL APPOINTMENT

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to the physician providing health care services to me via telemedicine.

I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Northern Virginia Gastroenterology P.C.

By signing this form, I certify that I have read and I fully understand its contents.

Physician's Name: _____

Patient's Name: _____

Signature: _____

Date: _____