

DO NOT WRITE IN THIS SECTION - FOR OFFICE USE ONLY

Time Admitted _____ Admit Date ____ / ____ / ____ MD/Therapist _____

Diagnosis

Treatment Services

Payment

- 303.90 Etoh Dependency
- 303.91 Etoh w/Intoxification
- 304.00 Opiate Dependency
- 304.10 Barbituate/Sedative Hypnotic
- 304.30 Cannabis Dependence
- 304.80 PolySubstance Dependence
- Other _____

- Detox
- Rehab
- Day Treatment
- Ambulatory Detox
- Individual Therapy
- Assessment Only
- IOP/Outpatient Services
- CATS Medication Clinic

- Self Pay
- County Patient
- Fairfax ADS Contract
- Insurance
- Juniper
- Vivitrol/Other Injection
- Suboxone

INOVA CATS - REGISTRATION FORM

PATIENT INFORMATION

_____ Last Name _____ First Name _____ Middle Init _____

_____ Address _____ Phone (H) _____

_____ City _____ State _____ Zip _____ Phone (Cell) _____

_____/_____/____ Date of Birth _____ Age _____ SSN _____ Race _____ Sex _____

Religious Preference _____ Marital Status _____

EMPLOYMENT INFORMATION

Place of Employment _____

_____ Address _____ Phone (W) _____

_____ City _____ State _____ Zip _____

Length of employment _____ Occupation _____

INSURANCE INFORMATION

Policy Holder's Name _____ SSN _____

Date of birth _____ Name of Employer _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

_____ Address _____ Phone (H) _____

_____ City _____ State _____ Zip _____ Phone (W) _____

LEGAL STATUS

Are you on Probation? Yes No Are you on Parole? Yes No Do you have charges pending? Yes No

Inova Staff: At the first opportunity, provide this Special Needs Form to ALL patients and companions. Use completed form to initiate appropriate action and place form in patient's chart.



Patient or companions: It is important to us to communicate thoroughly with all of our patients and companions. To ensure that we provide effective communication during your stay, please complete the information below.

In what language would you prefer to communicate with your providers?	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other (Specify) _____
Are you hard of hearing?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If your response is "No" to both questions, then sign the form below. If your response is "Yes" to one or both of the questions, then sign the form below AND complete the information on the Deaf or Hard of Hearing Communication Request Form .
Are you deaf?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

Patient's condition does not allow and/or the companion is not available to complete the Special Needs Form.

Spoken language interpreters are available on site or by phone. If you prefer to communicate in a non English language, trained interpreters will be provided to you.

If your communication needs or those of your companion change during your stay/visit, or you need further assistance, please let your caregiver know and we will make accommodations to assist you.

Signature of Patient/Patient Representative/Companion

Date

Print: _____

Relationship to Patient: Self Parent Family Member Friend Other _____

Signature of Employee Witness

Date

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

**INOVA HEALTH SYSTEM
SPECIAL NEEDS FORM**

CAT # 87498/R070811 • PKGS OF 100





1PMTREV

Patient Name: _____ Medical Record #: _____

Date of Service: _____ Location: _____ Account #: _____

1. **Physicians Who Are Not Employees or Agents of Hospital** – I understand that most of the physicians and surgeons furnishing services to me, either individually or through professional corporations including, but not limited to emergency department physicians, radiologists, anesthesiologists, neonatologists, physiatrists, pathologists, and others are independent contractors and are not employees or agents of Inova Health System or this Hospital. I understand that they are independent in the exercise of decisions requiring professional medical judgement, including decisions about my care. I understand that I may receive separate bills for such independent contractor services.
2. **Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from my insurance carrier(s)/health benefit plan(s) to Inova Health System (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any hospital and/or medical insurance benefits to which I am otherwise entitled, including any Major Medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Inova Health System (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.
3. **Unauthorized, Non-Covered, or Out of Plan Services** – I understand that if my insurance company or health maintenance organization does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to the Hospital and any independent contractors providing services to me/the patient for this admission or any service if determined by my insurance company or health maintenance organization to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. I also understand that certain physicians and surgeons, such as radiologists, anesthesiologists, neonatologist, physiatrists, pathologists and others may not be participating physician members of my managed care health plan. In the event that my managed health care plan does not reimburse these services provided to me, I acknowledge that I will be responsible for any balance that it declines to pay for such services.
4. **Authorization to Release Information and Process Claims** – I authorize release of information, including financial information and confidential health information and medical records regarding services rendered during this episode of care or any related services, which may include records relating to treatment for substance abuse, to my insurance carrier(s), managed care plan or other payor, including past and/or present employer(s), Medicare, Medicaid, or Tricare, authorized private review entities, and/or utilization review entities acting on their behalf, authorized chart reviewers and market surveyors of the Hospital, the billing agents and collection agents or attorneys of Inova Health System (or its affiliates) and/or independent contractor physicians and/or professional corporations, my employer's Workers' Compensation carrier, and, as applicable, the Social Security Administration, the Centers for Medicare & Medicaid Services, the Peer Review Organization acting on the behalf of the federal government, and/or any other federal or state agency for the purpose(s) of satisfying billed charges and/or facilitating utilization review and/or conducting chart review and market surveys and/or otherwise complying with the obligations of state or federal law. A photocopy of this authorization may be honored.
5. **Non Responsibility for Personal Property** – I understand and agree that the Hospital and Inova Health System (or its affiliates) cannot be responsible or liable for any theft of, loss of, or damage to any personal property or other possessions which are not placed in the Hospital's vault for safekeeping. I further understand and agree and authorize that any such money and/or belongings not claimed within sixty (60) days of my discharge from the Hospital may be destroyed or disposed of at the Hospital's discretion, and that any interest or right I may have had in such money or other valuables shall cease.
6. **For Medicare Recipients Only** – I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment. My signature below acknowledges receipt of "An Important Message from Medicare" on the date listed below.
7. **Patient Rights and Advance Directives** – Hospital patients have specific rights and a list is provided in the Patient Information Handbook and brochure that are provided to you by the Hospital. Federal and State laws also give you the right to complete a living will or select a durable power of attorney for health care. The Hospital's policy on Advance Directives and a brochure on Advance Directives will be made available to you upon request.
8. **Responsibility for Payment** – In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.
9. Residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in patient care as part of the Hospital's education programs.

By signing below, I certify that I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient listed above or am the guardian, duly authorized representative, parent or other family member of the patient.

PATIENT (GUARDIAN, ETC.)

DATE

RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

WITNESS

DATE

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM AUTHORIZATION FOR CLAIMS, PAYMENT, AND REVIEWS

White: Medical Records • Yellow: Patient Copy

INOVA COMPREHENSIVE ADDICTION TREATMENT SERVICES

**CONSENT AND AGREEMENT FOR PARTICIPATION IN THE
VIRGINIA PRESCRIPTION MONITORING SYSTEM**

The Virginia Prescription Monitoring System is a statewide electronic database which collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency. The housing agency distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession. Prescribers and dispensers may query the database to assist in determining treatment history and determine patient compliance with prescribed medications.

I, _____, agree and give consent for the Physician and his/her staff at Inova Comprehensive Addiction Treatment Services Inpatient and Outpatient Program, to use the Virginia Prescription Drug Monitoring Program as needed to verify and rule out any non-compliance of Prescription Drugs.

Patients Signature

Date

Time

Staff Signature

Date

Time

Addressograph

Inova Comprehensive Addiction Treatment Services
Consent for Virginia Prescription Monitoring System
November 22, 2010
MR# 10-91



1HIPAA

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342**.

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

**INOVA HEALTH SYSTEM
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

CAT #84498 / R020609
PKGS OF 100

MR 32-06

Effective Date: April 14, 2003

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.

If you have any questions about this notice, please contact the Chief Privacy Officer by calling the Compliance Department at 703-205-2337.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by and as part of the care furnished to you in an Inova facility or through an Inova service, whether made by Inova personnel, agents of Inova and its affiliated facilities, or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

Inova Health System's Responsibilities

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised copy by accessing our web site www.inova.org, calling 703-204-3342 and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures

How we may use and disclose Medical Information about you.

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

For Treatment: We may use medical information about you to provide you treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, we may provide a physician at the hospital with information regarding your prior treatment at an Inova facility if it might have bearing on the current condition for which you are being treated. Different Inova departments also may share medical information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your protected health information in order to support the business activities of Inova Health System. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our facilities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when we are ready to assist you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for Inova Health System. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about the services we offer or to send you information about products or services that we believe may be beneficial to you.

If you do not want to receive the materials described above, please contact our Chief Privacy Officer by calling our Compliance Department at 703-205-2337 and request that these fund raising materials not be sent to you.

We may use certain information (name, address, telephone number, dates of service, age, and gender) to contact you in the future to raise money for Inova Health System. We may also provide this information to our institutionally related foundation, for the same purpose. The money raised will be used to expand and improve services and programs we provide the community.

If you do not wish to be contacted for fund-raising efforts, please notify Inova Health System Foundation, 8110 Gatehouse Road, Falls Church, VA 22042, in writing.

Business Associates: Some of the services provided by Inova are provided through contracts with business associates. Examples may include transcription services or outside billing services with which we contract. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information. Inova's requirements for safeguarding your information are included in Business Associate Agreements with each such entity.

Directory: We may include certain limited information about you in the hospital directory while you are a patient at the hospital. The information may include your name, location in the hospital, your general condition (e.g., good, fair, etc.) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would prefer not to be included in the facility directory please request the Request to be Excluded Form from the Registration staff or from the Chief Privacy Officer.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you desire to limit disclosure of such information to friends or family members, we will ask that you designate one individual to whom we may make such disclosures. It will then be up to you to instruct that individual as to how they may disseminate information about you to other interested parties.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

Future Communications: We may communicate to you via newsletters, mailings or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which our facilities are participating.

Organized Health Care Arrangement: Inova Health System's facilities, including but not limited to its hospitals deliver care in clinically integrated settings in which individuals typically receive care from more than one health care provider including Inova's workforce, physicians and allied health practitioners who are in private practice and have clinical privileges at Inova facilities, hospital-based physician groups such as anesthesia, radiology, pathology and emergency medicine, department chairs and medical directors. These are all part of Inova's Organized Health Care Arrangement (OHCA) and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Single Covered Entity: For purposes of HIPAA only, all covered entities that are owned or controlled by Inova Health System shall be considered to be a Single Covered Entity. Protected health information will be made available to personnel at other facilities included in this Single Covered Entity, as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Chief Privacy Officer for further information on the specific sites included in this affiliated covered entity.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or legal authorities charged with preventing or controlling disease, injury or disability
- Correctional institutions
- Workers Compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners and medical directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the laws under Virginia Law are more stringent than Federal privacy laws, Virginia law preempts the Federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

- **Inspect and Copy:** You have the right to inspect and copy medical information in our possession that may be used to make decisions about your care. As a rule, this includes medical and billing records, but does not include psychotherapy notes.

We may deny your request to inspect and copy your records in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed health care professional not involved in the original denial of your request will be chosen by the Inova Health System to review your request and the denial. We will comply with the outcome of the review.

- **Amend:** If you feel that your medical information we have on file is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as Inova Health System retains the information.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

- **An Accounting of Disclosures:** You have the right to request an accounting of any disclosures we make of your medical information for purposes other than treatment, payment or health care operations.
- **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 your surgical procedure.

We are not required to agree to your request. All requests for restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations must be forwarded to the Chief Privacy Officer. Only the Privacy Officer or his/her designee can agree to such restrictions or limitations. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **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 may ask that we contact you at a location other than your home or by U.S. Mail. Such requests must be made in writing and must include a mailing address where bills for services and related correspondence regarding payment for services will be received. It is important that you note that Inova Health System reserves the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **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 may obtain a copy of this notice at our web site <http://www.inova.org>.

To exercise any of your rights, please obtain the required forms from the Chief Privacy Officer and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. The revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in Inova's facilities and will include the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will provide access to the most recent version. You may always access the most recent version at our web site <http://www.inova.org> or may call 703-204-3342 and request that a copy of the most recent version be mailed to you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital by contacting the Compliance Department and asking for the Chief Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

We are required to retain our records of the care that we provided to you. Inova Health System will make other uses and disclosures of medical information not covered by this notice or the laws that apply to us only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If we receive written revocation of your permission, we will cease the use or disclose medical information you originally authorized. We would not be able to take back any disclosures we had already made with your permission.

CHIEF PRIVACY OFFICER

Telephone Number: 703-205-2337

INOVA COMPREHENSIVE ADDICTION TREATMENT SERVICES
3300 GALLOWS ROAD
FALLS CHURCH, VA 22042
(703) 776-7777
(703) 776-7799 FAX

I, _____ authorize INOVA COMPREHENSIVE ADDICTION TREATMENT SERVICES TO OBTAIN FROM AND/OR DISCLOSE TO:

Name of individual and/or organization	Relationship
Street Address	Phone number
City	State
Zip code	Fax number

The following information/records:

Yes	No	Information to be disclosed
		Admission to the program
		Assessment and Diagnosis (Axis 1-5)
		Treatment plan goals and objectives
		Progress towards accomplishing treatment plan goals and objectives
		Results of drug screens and breathalyzer tests
		Compliance with treatment recommendations and referrals
		Program participation
		Diagnostic Lab Work
		Financial Documentation
		Other:

For the purpose of:

	Service coordination
	Participation in family program
	Completion of family interview
	Reports to Probation Office or Attorney
	Other:

I understand that my records are protected under Federal and State Confidentiality laws and cannot be disclosed without my written consent unless otherwise provided for in the law and regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand written notification is necessary to cancel this authorization and can be addressed to the department listed at the top of this form. I understand that in any event this consent automatically expires 90 days after the end of the continuum of treatment at Inova CATS. I understand that if the person or agency that receives my information is not a health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I further acknowledge that the information to be released was fully explained and that this consent was given of my own free will and understand Inova Comprehensive Addiction Treatment Services may not condition treatment on my decision to sign this authorization.

This consent includes information placed in my records after the date of the signature below.

Signature

Date

Note, where information accompanies this disclosure form. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Addressograph

INOVA COMPREHENSIVE ADDICTION TREATMENT SERVICES
Authorization to Release Protected Health Information
MR-10-56(REV 05/09)