Consent for Services

I consent and authorize Inova’s Medical House Calls program, its agents and associates to care for and treat me in my home and at Inova facilities. A representative of Inova has explained my plan of care and has answered all of my questions in a satisfactory manner. I understand that my treatment plan may change and, if so, these changes will be discussed with me and the final decision will be mine. Unless I object, my family/caregiver/medical Designated Decision Maker (DDM) will receive instructions to assist with my care. I agree to notify my health care team of any changes in my condition, any side effects of medications, or any other significant events related to my health and well-being.

Notice of Privacy Practices and Acknowledgement of Receipt

I understand that practices about the use and disclosure of medical information are described in the current Notice of Privacy Practices (enclosed). I certify that I have received Inova’s Notice of Privacy Practices and that I have a right to receive an additional copy upon request.

Patient Rights and Responsibilities

I have received a copy of Inova’s Patient Rights and Responsibilities (enclosed).

Authorization for Claims, Payment and Reviews

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf for any services furnished to me by Inova’s Medical House Calls program. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents and to my medical insurers any information needed to determine or secure eligibility information for these benefits.

I certify that all information given on my behalf is correct to the best of my knowledge. I understand that services provided to me by the Inova Medical House Calls program will be billed to my insurance plan(s), if any. I also understand that no patient is denied services due to an inability to pay for medical care. I may complete an application to determine if I am eligible for payment assistance through the Virginia Health Safety Net Program.
Guidelines

Your medical provider might already have made plans with you for regular medical house call appointments on a recurring schedule. The guidelines below do not refer to those plans, but instead address needs that arise unexpectedly.

Urgent Needs During Business Hours:

- Business hours are 8:00 am - 4:30 pm Monday-Friday, excluding holidays.
- Clinical office staff can usually respond to phone calls regarding urgent needs via telephone within one hour.
- A medical provider can usually respond with a visit to the home within 24-48 business hours.
- You need to dial 911 for an emergency.

Urgent Needs After Business Hours, During Weekends and on Holidays:

- Observe hour-of-day/night courtesy. The on-call provider can usually respond to calls within 20 minutes.
- The following MAY NOT be requested at night or during weekends:
  - refills of prescriptions
  - scheduling of routine visits for the coming week
  - prescriptions for controlled substances
  - form completion
- You need to dial 911 for an emergency.

If you call with an urgent request, it is possible that you may be advised to go to the Emergency Room.

Additional Guidelines:

- **Routine Appointment** - Call for a routine appointment the same way you would call any primary care office seeking an appointment. You may plan for a routine visit 1-2 weeks in advance or you may ask for an expedited appointment within a few days.
- **Prescription Refill** - Call for prescription refills at least 7 business days before you are out of any medication.
- **Forms Completion** - Call if you need forms completed by your provider and allow 7-10 business days (plus any time for testing needed) in order for provider to complete the forms.
Additional Guidelines: (continued)

- **Other Requests** - Call to coordinate for other requests as needed. Be aware that elective procedures scheduled by other medical providers do not prioritize our appointment schedule.
- If you have a non-urgent question or request that cannot be addressed by the clinical office staff, you may leave a message and a medical provider will return the call, generally within **24-48 hours**.

Your provider might need to obtain lab work and imaging as part of your medical care. If your provider determines there is a need for these services, they may be provided by an outside company. There may be costs associated.

I understand the information given above, and all my questions have been answered to my satisfaction.

<table>
<thead>
<tr>
<th>Patient/DDM (signature)</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

If DDM:

(print name):

(address):

(phone number):

Relationship:   ☐ Guardian ☐ DDM

Authority:   ☐ Other:

☐ Oral Consent Obtained (witness to oral consent must sign below)

Witness to Oral Consent (signature)   Date   Time

Witness to Oral Consent (print name)

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video   Interpreter name/ID number (if applicable)

☐ Patient/Designated Decision Maker was offered and refused interpreter   ☐ Waiver signed

Inova Medical House Calls
Admission Consents & Guidelines

Page 3 of 3
CAT #20870DT / R040122 • PKGS OF 50
**All items with an asterisk are MANDATORY fields.**  

**Do NOT use for CATS releases**

| **A** Patient Name ___________________________ | Medical Record Number ___________________________ |
| **Patient Date of Birth** ___________________________ | **Social Security# (last 4 digits)** ___________________________ |
| **Contact Phone Number** ___________________________ | **Contact Email** ___________________________ |
| **Patient Address** ___________________________ | **Street Address** ___________________________ |
| **City** ___________________________ | **State** ___________________________ |
| **Zip Code** ___________________________ |  |

| **B** I authorize Inova to (check one): |
| [ ] Release the information indicated to: |
| [ ] Request the information indicated from: |

Name of person or entity to receive or disclose information: ___________________________

| **C** Information to be Released/Disclosed: |
| Facility: ___________________________ |
| [ ] All Inova facilities |
| Dates of admission/treatment requested: ___________________________ |

| **(check all that apply):** |
| [ ] Billing Information |
| [ ] Complete Medical Record |
| [ ] Consultations |
| [ ] Discharge Summary |
| [ ] EKG/EEG |
| [ ] Emergency Room Records |
| [ ] History & Physical |
| [ ] Laboratory Reports |
| [ ] Medication List |
| [ ] Operative Reports |
| [ ] Pathology Reports |
| [ ] Physician Orders |
| [ ] Psychiatric Admit Note |
| [ ] Psychiatric Evaluation |
| [ ] Radiology Images/CD |
| [ ] Radiology Reports |
| [ ] Other (specify): ___________________________ |

| **D** Purpose (check all that apply): |
| [ ] Medical Follow-Up |
| [ ] Attorney |
| [ ] Personal Use |
| [ ] Disability |
| [ ] Insurance |
| [ ] Other ___________________________ |

| **E** Provide Record by Means of (check one): |
| [ ] MyChart |
| [ ] Fax (25 pages or less) |
| [ ] Electronic Media (CD) |
| [ ] Mail – Regular |
| [ ] Mail – Expedited. On request, Health Information Management can expedite record delivery. You will be billed for actual charges incurred. |
| [ ] In Person Review. You will need to make an appointment for the review. |
| [ ] Email – Encrypted |
| [ ] Email – Unencrypted |
| [ ] Pick-up |

**F** I understand if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that this disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.

I understand treatment will still be provided to me if I do not sign this form.

**Patient or Authorized Representative (signature) ___________________________**

**Date/Time (Authorization will expire six months after date signed) ___________________________**

**Patient or Authorized Representative (print name) ___________________________**

**Relationship to Patient (specify, or check box if “Self”) ___________________________**

**Interpreter Information** (To be completed by Inova staff, if applicable):

[ ] In person  [ ] Telephonic  [ ] Video  Interpreter name/ID number (if applicable) ___________________________

[ ] Patient/Designated Decision Maker was offered and refused interpreter  [ ] Waiver signed

**Inova Authorization to Request/Disclose Protected Health Information**

CAT # 81516/ RGS1520 • PAMS OF 100

4
Patient Identification Form

This form is to correctly identify the legal spelling of your first name, last name, middle initial and your date of birth. Accurate patient information is important for your safety while receiving services at any Inova facility.

Please Print Clearly

Legal First Name of Patient:________________________________________________________

Legal Middle Name of Patient:____________________________________________________

Legal Last Name of Patient:________________________________________________________

Address:_______________________________________________________________________

City       State       Zip Code

Phone Number:______________________ Social Security Number:_____________________

Date of Birth (Month / Day / Year):________________________ Gender: □ Male □ Female

Primary Care Physician:___________________________________________________________

Group Practice Name:____________________________________________________________

OR

□ I do not have a Primary Care Physician (check if applicable)

Signing this form acknowledges the above information is correct and will be used as patient identification at Inova.

Patient or Designated Decision Maker (DDM) (signature)    Date/Time

If signed by DDM:_________________________________________ DDM Relationship to Patient

DDM (print name)

Witness (signature)    Witness (print name)    Date/Time

Inova

Patient Identification Form

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name:_______________________________________________________________

Date of Medical Birth:________________________ Record #___________________________

Gender: □ Male □ Female
Please list the **names and phone numbers** of anyone currently involved in patients care.

Please call any non-Inova Providers and request that they send our office the 2 most recent visit notes. They can be faxed to the Medical House Calls office at 571-665-6878.

**Current PCP (Primary Care Provider)**
1.

**Specialists (cardiologist, nephrologist, dermatologist, etc.)**
1.
2.
3.
4.
5.

**Home Health Company (nursing, physical therapy, occupational therapy, etc.)**
1.

**Hospice or Palliative Company Name**
1.

**Care Manager, Social Worker, APS Worker, etc.**
1.
2.

**Caregiver/Aide/Private Pay Services**

**Company Name:**
1.

Days and times are caregivers in home?
The following pages are for your information only. They do not require any signature and they do not need to be returned to Inova.
Dear Valued Inova Patient,

Since April 2021, the majority of your patient care information is available to you through your MyChart account as soon as it is posted by your care team. This includes treatment notes, lab results, pathology, and test results.

Your care provider has ordered an important test, scan or procedure to help diagnosis or monitor a health condition, which might need to be addressed quickly. The results may indicate the need for further evaluation and treatment. Since notes and results are available for your review more quickly than in the past, you may see your results before your care provider has a chance to review them. All results will be addressed by your provider in a timely manner, and you can send your care team a message through MyChart if you have questions.

If you prefer to speak with your provider before you see your results in MyChart, you can easily update your communication preferences. Log into your MyChart account and follow these steps:

- Select “Menu” (top left of the page)
- Select “Account Settings”
- Select “Communication Preferences”
- Select ‘Health” and click to expand
- Under ‘Test Result, you can elect to receive all results in a single email by selecting ‘Receive a daily summary between 8-10 am….‘
- If you do not want to receive your results electronically, de-select the email icon.

Our team is prepared to answer your questions, so please do not hesitate to reach out for assistance as needed. For additional information, please visit our website at inova.org/mychart/opennotes.

Thank you,

Your Inova Care Team
INova Notice of Privacy Practices

Effective Date: November 15, 2014

This Notice Describes How Medical Information About You May Be Used and Disclosed At INova AND How You Can Gain Access to This Information.

Please Review It Carefully.

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

Each time you visit a hospital, physician, or other health care 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 information is considered protected health information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) requires that we provide you with a notice regarding how your PHI may be used or disclosed and your rights concerning that 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'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 PHI 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 website 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. If any major change is made to this Notice, it will automatically be provided to you at the time of your next visit to an INova facility. It will also be posted on our website at the time of the change.

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 personnel who are involved in taking care of you at INova. For example, we may provide a physician at an INova 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.

We may disclose medical information about you to people outside of INova who provide services that are related to your care. We may also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from an INova facility.

Payment: Your PHI 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 PHI in order to support the business activities of INova. 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 PHI 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 PHI as necessary to contact you to remind you of your appointment.
We may use or disclose your PHI 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 PHI 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. These activities are not considered to be marketing under the HIPAA Privacy Rule.

Use of your PHI for activities that would be considered marketing or disclosures that would constitute the sale of PHI may not be made without a signed authorization from 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 marketing materials not be sent to you.

We may use certain information to contact you in the future to raise money for Inova. 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.

Information that may be used about you for fundraising purposes includes your name, address, telephone number, dates of service, age, gender, general information about the department in which you received care, the identity of your treating physician and general outcome of your treatment.

If you do not wish to be contacted for fund-raising efforts, please notify the Inova Health System Foundation, at 8110 Gatehouse Road, Falls Church, VA 22042, or by calling 703-289-2072.

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. 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. In addition, all business associates are subject to oversight by the Secretary of Health and Human Services (HHS) and must adhere to all requirements of the HIPAA Privacy and Security Rules.

Directory: We may include certain limited information about you in a facility directory while you are a patient at the facility. The information may include your name, location in the facility, 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: Your medical information may be used or disclosed for research purposes without your permission if an Institutional Review Board (IRB) approves such use or disclosure. We may disclose medical information about you to researchers preparing to conduct a research project. In addition, researchers may contact you directly about participation in a study. The researcher will inform you about the study and give you an opportunity to ask questions. You will be enrolled in a study only after you agreed and signed a consent form indicating your willingness to participate in the study.

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’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; and other health care entities affiliated with Inova. These are all part of Inova’s Organized Health Care Arrangement (OHCA) and may utilize a shared electronic health record database. We are presenting you this document as a joint notice for these purposes. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to PHI in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Health Information Exchange: We may make your protected health information available electronically through an information exchange service to other health care providers that request your information. Participation in information
exchange services also lets us see health care information about you from other health care providers who participate in the exchange.

**Single Covered Entity:** For purposes of HIPAA only, all covered entities that are owned or controlled by Inova shall be considered to be a Single Covered Entity. PHI 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 PHI 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:

- in response to a court order, subpoena, warrant, summons or similar process;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at an Inova facility; and
- about wounds made by certain weapons.

**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 Virginia Law is more stringent than Federal privacy laws, Virginia law preempts the Federal law.

Uses or disclosures of your PHI not described in this notice will be made solely upon written authorization from you or your personal representative. Written authorizations may be revoked by contacting the department originally authorized to use/disclose the information.

**Your Health Information Rights:**

Although your health record is the physical property of the health care 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. You may request an electronic copy of your PHI maintained in Inova’s electronic health record (EHR). Access to your records must be provided within 15 days of the receipt of your request. 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 Inova to review your request and the denial. We will comply with the outcome of the review.

- **Request an Amendment of Your Information:** 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 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 and will be provided with your options as defined in the HIPAA Privacy Rule.

- **Request 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.

- **Right to Restrict Release of Information For Certain Services**
  - You have the right to request a restriction on disclosure of health information about services you paid for out of pocket in full. This request should be made prior to the service being provided and applies only if the disclosure is to a health plan for purposes of payment or health care operations.
  - 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 disclose information about your surgical procedure. Restrictions should be requested in writing by completing a Request for Confidential Communication and/or Disclosure Restriction. You may obtain a copy of this form at the time you register for your service or you may obtain one on our web site www.inova.org.

- With the exception of restrictions regarding services or procedures that you pay for out of pocket, we are not required to agree to your request. 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 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.

- **Breach Notification:** You have a right to be notified following a breach of your unsecured PHI.

- **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 under this notice, please obtain the required forms from the Registration Department in the facility where you received your services and submit your request in writing. You may also access these forms at our web site http://www.inova.org.

**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 Inova 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 is mailed to you.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Inova by contacting the Compliance Department at 8110 Gatehouse Road, Falls Church, VA 22042 Attention: Chief Privacy Officer. You may file a complaint with the Secretary of the Department of Health and Human Services. Instructions for filing a complaint with the Secretary are found at: www.hhs.gov/ocr/privacy.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint about Inova’s Privacy practices.**

**OTHER USES OF MEDICAL INFORMATION**

We are required to retain our records of the care that we provided to you. Inova 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
VIRGINIA ADVANCE MEDICAL DIRECTIVE

I, ____________________________, intentionally and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows:

I understand that my advance directive may include the selection of an agent in addition to setting forth my choices regarding health care. The term "health care" means: the furnishing of services to any individual for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability, including but not limited to medications; surgery; blood transfusions; chemotherapy; radiation therapy; admission to a hospital, nursing home, assisted living facility or other health care facility; psychiatric or other mental health treatment; and life-prolonging procedures and palliative care.

The phrase "incapable of making an informed decision" means: unable to understand the nature, extent and probable consequences of a proposed health care decision; unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision; or unable to communicate such understanding in any way.

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

(YOU MAY INCLUDE IN THIS ADVANCE DIRECTIVE ANY OR ALL OF SECTIONS I THROUGH V BELOW.)

SECTION I: APPOINTMENT OF AGENT
(CROSS THROUGH SECTION I AND SECTION II BELOW IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU)

I hereby appoint the following as my primary agent to make health care decisions on my behalf as authorized in this document:

<table>
<thead>
<tr>
<th>Name of Primary Agent</th>
<th>Telephone</th>
<th>E-mail if any</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

If the above-named primary agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following as successor agent:

<table>
<thead>
<tr>
<th>Name of Successor Agent</th>
<th>Telephone</th>
<th>E-mail if any</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

I hereby 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 is effective as long as I am incapable of making an informed decision.

In exercising the power to make health care decisions on my behalf, my agent shall follow my desires and preferences as stated in this document or as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or non-treatment. My agent shall not make any decision regarding my health care which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing. If my agent cannot determine what health care choice I would have made on my own behalf, then my agent shall make a choice for me based upon what he or she believes to be in my best interests.

My agent shall not be liable for the costs of health care that he or she authorizes, based solely on that authorization.
SECTION II: POWERS OF MY AGENT

(CROSS THROUGH ANY POWERS IN THIS SECTION IF YOU DO NOT WANT TO GIVE YOUR AGENT AND ADD ANY POWERS OR INSTRUCTIONS THAT YOU DO WANT TO GIVE YOUR AGENT.)

The powers of my agent shall include the following:

A. To consent to or refuse or withdraw consent to any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization specifically includes the power to consent to the administration of dosages of pain-relieving medication in excess of recommended dosages in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or of inadvertently hastening my death.

My agent’s authority under this Subsection A shall be limited by any specific instructions I give in Section IV below regarding my health care if I have a terminal condition.

B. To request, receive and review any oral or written information regarding my physical or mental health, including but not limited to medical and hospital records, and to consent to the disclosure of this information.

C. To employ and discharge my health care providers.

D. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, assisted living facility or other medical care facility. If I have authorized admission to a health care facility for treatment of mental illness, that authority is stated in Subsections E and/or F below.

E. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided that I do not protest the admission and provided that a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

F. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days, even if I protest, if a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

(If you give your agent the powers described in this Subsection F, your physician must complete the following attestation.)

Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.

Physician Signature ___________________ Date ______________

Physician Name Printed ___________________

G. To authorize the following specific types of health care identified in this advance directive even if I protest.

(Specify cross-reference any applicable sections of this advance directive.)

(If you give your agent the powers described in this Subsection G, your physician must complete the following attestation.)

Physician attestation: I am the physician or licensed clinical psychologist of the declarant of this advance directive. I hereby attest that I believe the declarant to be presently capable of making an informed decision and that the declarant understands the consequences of this provision of this advance directive.

Physician Signature ___________________ Date ______________

Physician Name Printed ___________________
J. To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law that aims to increase scientific understanding of any condition that I may have or otherwise to promote human well-being, even though the study offers no prospect of direct benefit to me.

K. To make decisions regarding visitation during any time that I am admitted to any health care facility, consistent with the following directions:

L. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

(Add below any additional powers you give your agent, limits you impose on your agent or other information to guide your agent.)

I further instruct my agent as follows:

SECTION III: HEALTH CARE INSTRUCTIONS
(Cross through subsections A and/or B below if you do not want to give additional specific instructions about your health care.)

A. I specifically direct that I receive the following health care if it is medically appropriate under the circumstances as determined by my attending physician:

B. I specifically direct that the following health care not be provided to me under the following circumstances:
(You also may specify that certain health care not be provided under any circumstances.)

SECTION IV: INSTRUCTIONS ABOUT END-OF-LIFE CARE (“LIVING WILL”)
(Cross through this section IV if you do not want to give specific instructions about your health care if you have a terminal condition.)

If at any time my attending physician should determine that I have a terminal condition where the application of life-prolonging procedures — including artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition and artificially administered hydration — would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. If I am an organ, eye or tissue donor (see Section V below), I want this instruction applied in such a manner as to ensure the medical suitability of my organs, eyes and tissues for donation.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this advance directive shall be honored by my family and physician as the final expression of my legal right to refuse health care and my acceptance of the consequences of such refusal.

(Cross through Subsections A and/or B below if you do not want to give additional instructions about care at the end of your life.)

A. OTHER DIRECTIONS ABOUT LIFE-PROLONGING PROCEDURES
(If you wish to provide your own directions about life-prolonging procedures, or if you wish to add to the directions you have given above, you may do so in this Subsection A. If you wish to give specific instructions regarding certain life-prolonging procedures, such as artificial respiration, cardiopulmonary resuscitation, artificially administered nutrition and artificially administered hydration, this is where you should write them. If you give specific instructions in this Subsection A, cross through any of the language above in this SECTION IV if your specific instructions that follow are different.)
I direct that:

---

**B. DIRECTIONS ABOUT CARE OTHER THAN LIFE-PROLONGING PROCEDURES**

(You may give here any other instructions about your health care if you have a terminal condition aside from your instructions about life-prolonging procedures, which are addressed in Subsection A above.)

I direct that:

---

**SECTION V: ANATOMICAL GIFTS**

(You may use this document to record your decision to donate your organs, eyes and tissues or your whole body after your death. If you do not make this decision here or in any other document, your agent can make the decision for you unless you specifically prohibit him/her from doing so, which you may do in this or some other document. Check one of the boxes below if you wish to use this section to make your donation decision.)

- I donate my organs, eyes and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes or tissues for donation. I understand that I may register my directions at the Department of Motor Vehicles or directly on the donor registry, www.DonateLifeVirginia.org, and that I may use the donor registry to amend or revoke my directions; OR

- I donate my whole body for research and education.

[Write here any specific instructions you wish to give about anatomical gifts.]

---

(You must sign below in the presence of two witnesses.)

**AFFIRMATION AND RIGHT TO REVOKE.** By signing below, I state that I am emotionally and mentally capable of making this advance directive and that I understand the purpose and effect of this document. I understand that I may revoke all or any part of this document at any time (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this advance directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.

Signature of Declarant  Date

The declarant signed the foregoing advance directive in my presence.

(Witness)  (Witness)

This form satisfies the requirements of Virginia's Health Care Decisions Act. If you have legal questions about this form or would like to develop a different form to meet your particular needs, you should talk with an attorney. It is your responsibility to provide a copy of your advance directive to your treating physician. You also should provide copies to your agent, close relatives and/or friends. For information on storing this advance directive in the free Virginia Advance Health Directive Registry, go to http://www.VirginiaAdvanceRegistry.org. This form is provided by the Virginia Hospital & Healthcare Association as a service to its members and the public. (June 2012, www.vhha.com)
Patients' Rights and Responsibilities:
The following list of rights and responsibilities does not presume to be all-inclusive, but is intended to show our concern for you and to emphasize the need for observance of these rights and responsibilities.

As a patient, you have the right to . . .

- Considerate and respectful care provided in a safe environment, free from all forms of abuse, harassment or discrimination.
- Participate in the development and implementation of your plan of care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Upon your request, have a family member, chosen representative and/or your own physician notified promptly of your admission to the facility.
- Not undergo any procedure unless you or your legally authorized representative gives voluntary, competent and understanding consent.
- Be well informed about your illness, possible treatments, and likely outcomes of care (including unanticipated outcomes) and to discuss this information with your doctor. You have the right to designate someone to receive this information on your behalf.
- Have a designated representative present for any updates provided regarding your routine course of care. In an emergency, when you lack decision-making capacity and the need for treatment is urgent, the information is made available to another person on your behalf. We will communicate to your designated representative any significant changes in your status, such as transfer to a higher level of care or need for unplanned emergency procedures as soon as clinical care allows.
- Have an advance directive (such as health care proxy, organ donation or living will) and the expectation that Inova will honor the intent of the directive to the extent permitted by law and facility policy.
- Confidentiality of your treatment records, unless you have given permission to release information or if reporting is permitted or required by law.
- Leave the facility even against the advice of your physician.
- Know the name of the physician, clinical psychologist, or other practitioner who has primary responsibility for coordinating your care, treatment, or services.
- Be told of alternatives when facility care is no longer appropriate.
- Be informed by your physician of the continuing healthcare requirements following your visit to or discharge from the facility.
- Access to interpreter services free of charge.
- The privacy of your medical information. Disclosures regarding you, your rights and our obligations regarding the use and disclosure of your medical information are made in accordance with our Notice of Privacy Practices.
- If you choose, you may also contact the Virginia Department of Health, Office of Licensure and Certification, 9800 Mayland Drive, Suite 401, Richmond, VA 23233, or call 800-955-1819. Additionally, you may contact the Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, or at www.jointcommission.org using the "Action Center" on the home page of the web site.

File a grievance by calling 703-205-2175, if you believe that Inova has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Patient Relations staff or manager is available to help you.

As a patient, you are responsible for:

- Providing complete and accurate information about your health, including past illnesses, facility stays, use of medications, and other matters relating to your health.
- Asking questions when you do not understand what you have been told about your care or what you are expected to do.
As a patient, you are responsible for: (continued)

- Following the care, service or treatment plan developed for you.
- Understanding that patients may not photograph, videotape, record or film any person or practice on Inova property without prior permission from Inova. This applies to your visitors as well.
- Recognizing that all medications you will take while in the facility will be prescribed by your doctor, dispensed by the facility Pharmacy and administered by a nurse or therapist.
  - Patients may not take their own medications, unless allowed by facility protocol.
  - Patients may not keep medications at their bedside.
- Telling your doctor if you believe you cannot follow through with your treatment plan and understanding the possible results if you decide not to follow the recommended treatment plan.
- Providing the facility with accurate contact and billing information.
- Having detailed knowledge of your health insurance coverage including deductibles, co-pays and network coverage.
- Being respectful to staff. This applies to your visitors as well.
- Being respectful of other patients and facility property and following facility rules and regulations. This applies to your visitors as well.
- Recognizing that the facility cannot accept responsibility for any personal property.

Notice of Deemed Consent for Infectious Disease Testing:
Virginia Code Section 32.1-45.1 provides that when either a person providing health care or a patient is directly exposed to the bodily fluids of the other in a way that may transmit human immunodeficiency virus (HIV) or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Consent for Treatment:

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care of the care of my minor child or the patient named below.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety. Laboratory tests may include testing for HIV and I understand that I have the right to decline testing for HIV.
- I understand that Inova utilizes an electronic medical record system.
- I authorize the release of my prescription history to my Inova physician from any pharmacy or drug monitoring agency.
- By signing below, I acknowledge and accept the patient rights and responsibilities outlined above and consent to treatment.

SIGNATURE NOT REQUIRED

<table>
<thead>
<tr>
<th>Patient/Guardian/etc. (signature)</th>
<th>Patient/Guardian/etc. (print name)</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Relationship to Patient (if not signed by patient)

<table>
<thead>
<tr>
<th>Witness (signature)</th>
<th>Witness (print name)</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Interpreter Information (To be completed by Inova staff, if applicable):

☐ No Interpreter Required

☐ In person ☐ Telephonic ☐ Video

Interpreter name/ID number (if applicable)

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name:
Date of Medical Birth:
Gender: ☐ Male ☐ Female

Inova

Patient Rights and Responsibilities

Page 2 of 2
CAT # 20170017 / R000110 • PK032-0500
Notice of Non-Discrimination

As a recipient of federal financial assistance, Inova Health System ("Inova") does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, sex, disability, or age in admission to, participation in, or receipt of the services or benefits under any of its programs or activities, whether carried out by Inova directly or through a contractor or any other entity with which Inova arranges to carry out its programs and activities.

This policy is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act, and regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at 45 C.F.R. Parts 80, 84, 91 and 92, respectively.

Inova:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please let our staff know of your needs for effective communication.

If you believe that Inova has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling 703.205.2175. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Patient Relations staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201 1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Interpreter Services are available at no cost to you. Please let our staff know of your needs for effective communication.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spanish</td>
<td>Atención: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Por favor infórmele a nuestro personal sobre sus necesidades para lograr una comunicación efectiva.</td>
</tr>
<tr>
<td>Korean</td>
<td>알려드릴니다: 귀하가 한국어를 구사한다면 무료 언어 도움 서비스가 가능합니다. 효과적인 의사전달을 위해 필요한 것이 있다면 저희 실무자에게 알려주시기 바랍니다.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Chú ý: Nếu quý vị nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ có sẵn miễn phí cho quý vị sử dụng. Xin vui lòng thông báo cho nhân viên biết bahwa câu hỏi quý vị đề gia nhập tiếp hiểu quả hơn.</td>
</tr>
<tr>
<td>Chinese</td>
<td>注意：如果你說中文，可以向你提供免費語言協助服務。請讓我們的員工了解你的需求以進行有效溝通。</td>
</tr>
<tr>
<td>Arabic</td>
<td>انتباة: إذا كنت تتحدث العربية، توفر الخدمات المجانية للمساعدة في اللغة. برجى إعلام فريق العمل بأحتاجائك من أجل الحصول على عملية تواصل فعالة.</td>
</tr>
<tr>
<td>Farsi</td>
<td>توجه: آگر به زبان فارسی صحبت می کنید، تسیمیات زبانی به صورت رایگان برای شما فراهم خواهد شد. به منظور برقراری ارتباط مؤثر، کارکنان ما را از نیازهای خود مطلع کنید.</td>
</tr>
<tr>
<td>Amharic</td>
<td>ከንጩር እስከ ከፍተኛ ከነ ከጭም እንጭእ ከሆነ ከላሸቸው የስክርቸው የወሰደ ከሚካራ ይፈላጉ ያለበት፣ ከማይሆን ከስክርቸው ከማካራን ይፈላጉ ያለበት:</td>
</tr>
<tr>
<td>Urdu</td>
<td>توجہ: آگر آپ اردو بولتے ہیں تو، زبان امداد خدمات، مفت مم، آپ کو دستی پر. موثر مواصلات کی آئی برائے مبین مکمل کاری عمل کو اپنے ضروریات کی بارے میں بات کہیں.</td>
</tr>
<tr>
<td>French</td>
<td>Attention: Si vous parlez Français, des services d'aide linguistique vous sont proposés gratuitement. Veuillez informer notre personnel de vos besoins pour assurer une communication efficace.</td>
</tr>
<tr>
<td>Russian</td>
<td>Внимание: Если вы говорите на русском языке, для вас доступны бесплатные услуги помощи с языком. Для эффективной коммуникации, пожалуйста, дайте персоналу знать о ваших потребностях.</td>
</tr>
<tr>
<td>Hindi</td>
<td>कृपया ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि-स्वतंत्र भाषा सहायता सेवा उपलब्ध है। कृपया प्रशासकीय संगठन-संरक्षण हेतु अपनी आवश्यकताओं के बारे में हमारे कर्मचारियों को बताएं।</td>
</tr>
<tr>
<td>German</td>
<td>Achtung: Wenn Sie Deutsch sprechen, stehen kostenlose Service-Sprachdienstleistungen zu Ihrer Verfügung. Teilen Sie Ihrem Team bitte Ihre Wünsche für eine effektive Kommunikation mit.</td>
</tr>
<tr>
<td>Bengali</td>
<td>উদ্ধৃতি আকর্ষণ করুন: আপনি যদি বাংলা বলতে পারেন, তাহলে আপনার জন্য বিভিন্ন ভাষা সহায়তা সেবা পাওয়া যাবে। আমাদের কর্মকর্তাদের জন্য আপনার প্রয়োজনীয়তার বিষয়ে আমাদের কর্মচারীদের ধারণ।</td>
</tr>
<tr>
<td>Kru (Bassa)</td>
<td>Tô Đài Nám Dylvín Cáo: C jà ké nà dël Gôôs-wôôg (Bôô-gôôg) po ní, ní, à bèdè gloo-kpa-kpa bô wulú-dô kô-kô po-nyô bè bîl nô à gloô sô pîdy. X dël dô mô nô à gloô nî, th me nyuè bè à kàà-nyô sô sô dî duè dî dyôu, ké à ké mô ké mie jè cèl nîmô dylvín.</td>
</tr>
<tr>
<td>Ibo</td>
<td>Nụbụma: O bụrụ na i na asụ Igbo, ọrụ enye maka asụsụ, n’efu, diiri gị. Biko mee ka ndị ọrụ anyi mara mkpa gị maka nkwukpịta ga-aga nke ọma.</td>
</tr>
<tr>
<td>Yoruba</td>
<td>Akiyesi: Bi o ba nso Yoruba, awọn isẹ iranlọwọ ede wa l’ofe fun ọ. Jowo je kí ara ịbiṣẹ wa mọ ọpọ awọn aini re fun ibaraenisiọọ ti o munadoko.</td>
</tr>
</tbody>
</table>

INOVA®