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>
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<th>If DDM:</th>
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<td>(phone number):</td>
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<td>Relationship:</td>
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☐ **Oral Consent Obtained** *(witness to oral consent must sign below)*

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<th>Witness to Oral Consent (signature)</th>
<th>Date</th>
<th>Time</th>
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<th>Witness to Oral Consent (print name)</th>
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**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

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**Inova Medical House Calls**

**Admission Consents & Guidelines**
Patient's Name: ___________________________ History #: ___________________________

Patient's Date of Birth: ___________________________ Date(s) of Service: ___________________________

Patient's phone number: (_____) ___________________________ (_____) ___________________________ DAYTIME EVENING

I authorize: __________________________________________

to release or disclose the following information to:

Inova Medical House Calls
NAME OF PERSON, PHYSICIAN OR AGENCY TO RECEIVE INFORMATION
571-665-6878
(FAX NUMBER FOR PHYSICIAN OFFICE ONLY)

2700 Prosperity Ave Suite 270 Fairfax Va 22031
STREET ADDRESS CITY STATE ZIP CODE

Information to be Released / Disclosed:

☐ Emergency Record ☐ X-ray Report
☐ Face Sheet ☐ Progress Notes
☐ Discharge Summary ☐ Lab / EKG
☐ Psychiatric Admit Note ☐ Operative Report
☐ Psychiatric Evaluation ☐ Physicians Orders
☐ Consultation ☐ Other ___________________________

Purpose:

☐ Medical Follow-Up ☐ Individual use
☐ Attorney ☐ Disability
☐ Other ___________________________

Patient advised of charges:  ☐ Yes ☐ No ☐ N/A

☐ I prefer to pick up records  ☐ I wish to review records (by appointment only)

I understand that 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 and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand that I am under no obligation to sign this form. Inova Health System may, however, condition the provision of research-related treatment on my signature of this authorization for the use or disclosure of protected health information for such research, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, §164.508(b)(4). Inova Health System may also condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signature of this authorization.

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part 2).

__________________________________________  ___________________________
SIGNATURE OF PATIENT OR REPRESENTATIVE DATE (This authorization will expire 6 months after date signed)

______________________________  ___________________________
NAME OF PERSONAL REPRESENTATIVE (IF APPLICABLE) RELATIONSHIP TO PATIENT

INOVASH HEALTH SYSTEM
INOVASH INITIATED AUTHORIZATION TO RELEASE / DISCLOSE PROTECTED HEALTH INFORMATION

CAT #84515 / R032402 • PKGS OF 100
The following pages are for your information only. They do not require any signature and they do not need to be returned to Inova.
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 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. 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 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/discard 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:

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<th>Name of Primary Agent</th>
<th>Telephone</th>
<th>Fax/Fax</th>
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<td>Address</td>
<td>E-mail if any</td>
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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:

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<th>Name of Successor Agent</th>
<th>Telephone</th>
<th>Fax/Fax</th>
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<tbody>
<tr>
<td>Address</td>
<td>E-mail if any</td>
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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 nontreatment. 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 II THAT 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.

(Specifically 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

H. To continue to serve as my agent even if I protest the agent’s authority after I have been determined to be incapable of making an informed decision.

I. To authorize my participation in any health care study approved by an institutional review board or research review committee according to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me.

—page 2 of 4—
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:

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**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:

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**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.]

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(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.VirginiaRegistry.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) • VcH
If You Have Questions, Concerns or Comments

At Inova, we recognize the importance of effective communication between you and our dedicated healthcare team. We encourage you to ask questions and share concerns while you are in the hospital so that those who are caring for you can provide prompt, courteous solutions to any issues that may arise.

Additionally, the hospital’s patient representatives are available to help patients and families with problems, clarify hospital policies, and assist with disability access issues or other special needs. The Patient Relations program has a process to address all complaints and grievances. Patient representatives welcome the opportunity to assist you, and can be reached at the phone numbers listed below.

Patient Representative Contact Numbers

Inova Alexandria Hospital ................. 703.504.3128
Inova Fairfax Medical Campus ............. 703.776.3663
- Inova Fairfax Hospital
- Inova Children’s Hospital
- Inova Heart and Vascular Institute
- Inova Women's Hospital
Inova Fair Oaks Hospital ................. 703.391.3607
or 703.391.3885
Inova Loudoun Hospital .................. 703.858.6795
Inova Mount Vernon Hospital .......... 703.664.7555

We hope you will allow us the opportunity to assist with any issues that may arise during your hospital stay. If you choose, you may also contact the Virginia Department of Health, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, VA 23233, or call 800.995.1919.

Additionally, you may contact the Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL 60181, or call 800.994.6610.

Insurance Concerns

If you have questions or concerns about decisions made by your health insurance plan, contact the Managed Care Ombudsman at 877.310.6560.

Ethics Consultation

Our hospitals’ Ethics Committees provide consultation services to help a patient or family deal with questions of life and death, as well as the quality of life. The Ethics Consultation team helps patients, families, physicians and hospital staff talk about appropriate plans of care when an ethical dilemma exists. The role of the team is to advise; it does not judge or make decisions. Its assistance is intended to help clarify issues for the patient and family members involved, and give them the information they need to make decisions.

Anyone directly involved with a patient can seek consultation on the patient’s behalf, including the patient, family members, friends, physicians, nurses, as well as other members of the patient’s care team.

To contact a member of our hospital’s Ethics Consultation team, call the hospital operator or the hospital’s patient representative.

Your Healthcare Decisions

You have the right to complete an Advance Directive which shares your wishes if you are unable to make healthcare decisions for yourself. An Advance Directive can include:

- Designating someone to make healthcare decisions for you and the types of decisions they can make
- Specific healthcare decisions to include end-of-life decisions
- Organ donation decision

It is our policy to respect your wishes in accordance with the law and the hospital’s policies. If your attending or treating physician has a personal conscience-based objection to the stated wishes in your Advance Directive (for example, reproductive or end-of-life decisions), under Virginia Code 54.1-2987 and Inova policy, the physician must make a reasonable effort to transfer your care to another physician willing to comply with your wishes.

If you have an Advance Directive, please provide us with a copy. If you would like more information on Advance Directives, please ask your nurse or patient representative.

inova.org/patientrights
Patient Rights and Responsibilities

We can provide better healthcare services when you and your family work together as partners with our staff and physicians. It is our responsibility to advise you of your rights as a patient; you also have responsibilities in your treatment and care. We urge you to ask questions, be proactive and take an active part in your care plan. If you have questions or concerns, please discuss these with your doctor, any staff member or contact the hospital’s patient representative.

Overview of Patient Rights

While you are in our hospital, you have certain rights as a patient. You have the right to:

- Receive treatment regardless of your age, gender, race, national origin, language, religion, sexual orientation, disability or any other discrimination prohibited by law.
- Know the names and titles of your healthcare team members.
- Receive information in a language or manner you understand. This includes the right to interpreter services at no cost to you.
- Be informed about possible results of care, treatment and services, including unexpected results.
- Be informed and involved in making healthcare decisions.
- Agree to or refuse care, treatment and services.
- Appropriate evaluation and management of pain.
- Courteous and respectful care.
- Be free from restraints of any form that are not medically necessary.

- Receive visitors designated by the patient, including but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member or a friend. Also included is the right to withdraw or deny such consent at any time.
- Be informed of the hospital’s practice that allows for the presence of a support individual unless it interferes with the rights of others, or is not recommended for medical reasons.
- Have a family member or representative, and your physician, notified of your admission.
- Prepare an advance directive to make certain your healthcare choices are followed if you are unable to communicate those choices to us.
- Receive care in a safe setting, free of all forms of abuse or harassment.
- A hospital setting that preserves dignity and contributes to a positive self-image.
- Respect for your cultural and personal values, beliefs, and preferences, as well as an opportunity to take part in religious and other spiritual services.
- Contact protective and advocacy services.
- Expect that the hospital will protect your confidentiality and respect your privacy.
- See your medical record; request amendments to your medical record; and request a list of persons or organizations to whom your health information was disclosed as determined by federal or state law.
- Give permission to the recording or filming made for purposes other than identification, diagnosis or treatment. You also have the right to cancel this agreement.
- Agree or refuse to participate in research studies.

- File a complaint and not be subject to discrimination, force, punishment or unreasonable interruption of care, treatment or services.
- Have your hospital bill explained and receive information about financial help.

Patient Responsibilities

As a patient, you are responsible for the following:

- Providing complete and accurate information about your health, including past illnesses, hospital 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.
- Following the care, service or treatment plan developed for you.
- 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 hospital with accurate contact and billing information.
- Detailed knowledge of your health insurance coverage including deductibles, co-pays and network coverage.
- Being considerate of other patients, staff and hospital property and following hospital rules and regulations. This applies to your visitors as well.
- Providing necessary information for insurance claims and to pay your bills or make arrangements for financial obligations in a timely manner.
- Recognizing that the hospital cannot accept responsibility for any personal property not deposited in the hospital safe.

Rights of the Disabled

When serving the disabled, our hospital continually strives to meet the objectives of the Americans with Disabilities Act (ADA) and the Virginians with Disabilities Act. If you encounter any physical or communication barrier during your time at our hospital, or if you believe you have been denied access to the hospital’s full array of services because of your disability, please contact the Compliance Department at 703.205.2337 or the patient representative.

Services for the Deaf and Hard of Hearing

To ensure effective communication with patients, their family members, and companions who are deaf or hard of hearing, we provide auxiliary aids and services free of charge, such as:

- Signed language and oral interpreters.
- Telecommunications typewriters for the deaf or hearing impaired (TTY/TDD).
- Video remote interpreting (VRI).
- Written materials.
- Telephone handset amplifiers.
- Assistive listening devices (marketed as a PocketTalker or Posey sound amplifier).
- Telephones compatible with hearing aids.
- Open and closed captioning of most hospital television programs.

Please ask your nurse or other hospital personnel for assistance, or contact 703.776.7641.
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 1-800-866-1019, 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>Text</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 informe a nuestro personal sobre sus necesidades para lograr una comunicación efectiva.</td>
</tr>
<tr>
<td>Korean</td>
<td>알려드릴립니다: 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 như câu của quý vị để giao tiếp hiệu 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>انتبهات: إذا كنت تتحدث العربية، توفر الخدمات المجانية للمساعدة في اللغة. يرجى إعلام فريق العمل باحتياجاتك من أجل الحصول على عملية تواصل فعالة.</td>
</tr>
<tr>
<td>Farsi</td>
<td>توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی به صورت را یک‌گان برای شما فراهم خواهد بود. به منظور برقراری ارتباط مؤثر، کارکنان ما را در نیازهای خود مطمئن کنید.</td>
</tr>
<tr>
<td>Amharic</td>
<td>ማስታወቪል: እናት የሚታወቪል ከኖር ከፋዳራዎች ከፋዳራዊ ከማስቀመያዎች ከ🐵 ከሚቻልበት ከፋዳራዊ ከማስቀመያዎች ከ자를 ይመረጋገጡ።</td>
</tr>
<tr>
<td>Urdu</td>
<td>توجہ: اگر آپ اردو بولتے ہیں تو، زبان امداد خدمات، مفت میں، آپ کو دستیاب پہی. مؤثر مواصلات کے لئے برائے ممکنہ معاہدات کے بارے میں حمایت کی ممکن ہیں۔</td>
</tr>
<tr>
<td>French</td>
<td>Attention: Si vous parlez Francais, 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 विशेष आशरण उपलब्ध है। कृपया प्रभावी संचार-संपर्क हेतु आपको 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 unserem Team bitte Ihre Wünsche für eine effektive Kommunikation mit.</td>
</tr>
<tr>
<td>Bengali</td>
<td>দৃষ্টি আকর্ষণ কৃত্রিম: আপনি যদি বাংলা বলতে পারেন, তাহলে আপনার জন্য বিশেষ সহযোগিতা সরবরাহ করা যায়। অনুরূপ করে কর্মকর্তা যোগাযোগের জন্য আপনার প্রয়োজনীয়তার বিবেচনা আমাদের কর্মীদের জানান।</td>
</tr>
<tr>
<td>Kru (Bassa)</td>
<td>Tô Đuô Nôm mô Dyôń Cáọ: J jô kô m dì dyô 553-wúũń (Bâ53-wûń) pô nȋ, nî, à bèdè gbo-kpâ-kpâ bà wdu-dù kô-kô pô nyỳ bë hî nî à gbo bô pédy. M dyô qè tô mô nî à gbo nî, mî me nyue bë à kû-a nyỳ bë dë kë dyô dyû, kë à kô mô kô më cëlín nôm mô dyôn.</td>
</tr>
<tr>
<td>Yoruba</td>
<td>Akiyesi: Bi o ba nso Yoruba, awon iṣe ọranlowo ede wa l'ọfẹ fun ọ. Jowo je ki ara ibiṣe wa mo nipawon aini ẹrẹ fun ibaraenisorọ ti o munadoko.</td>
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