4038 Thomas Nelson Hwy, Arrington, VA 22922 ● Ph: 434.263.4000 ● Fax: 434.263.4160

Welcome!

Dear New Patient:

Welcome, and thank you for choosing Blue Ridge Medical Center (BRMC) for your health care needs. Once registered, you are eligible for services at all our locations, including Blue Ridge Medical Center Amherst, Blue Ridge Medical Center Appomattox, Blue Ridge Medical Center Pharmacy and at the Blue Ridge Dental Center. Please fill out all forms in the enclosed packet and return them to the Medical Center before your appointment. Having the documents in advance will make your check-in process go much faster.

The forms included in this packet are:

Patient Registration	Return to BRMC
Privilege to discuss/HIPAA Consent Form	Return to BRMC
Request for Medical Records	Return to BRMC
Health History Questionnaire	Return to BRMC
No Show Policy	Return to BRMC
BRMC Website Access Form	Return to BRMC (if applicable)
Financial Assistance (If Applicable)	Return to BRMC (if applicable)
Telemedicine: What to expect	Return to BRMC
Telemedicine Consent Form	Return to BRMC
Patient Rights and Responsibilities	For your information
Notice of Privacy Practices	For your information

Forms that are incomplete will be returned.

Please contact us as soon as possible if you have questions about any of the forms. We will be happy to assist you. And again, thank you for choosing Blue Ridge Medical Center

Sincerely,

Blue Ridge Medical Center
434.263.4000

Patient Registration Form

Date: ______________

Registration is for ☐ **Medical (BRMC)** ☐ **Dental (BRDC)** ☐ **Both**

Patient Information		
Last Name:	First Name:	MI:
Adress:		DOB:
City:	State:	Zip Code:
Phone Numbers & Email		
Principal:	◯ Cell	◯ Home
Secondary:	Work:	
Email:		

S.O./G.I

Sex Assigned at Birth:

◯ Male ◯ Female ◯ Unknown ◯ Other:

Sexual Orientation:

◯ Straight ◯ Lesbian/Gay ◯ Bisexual
◯ Don't know ◯ Choose not to disclose ◯ Other:

Gender Identity:

◯ Male ◯ Female ◯ Transmasculine
◯ Transfeminine ◯ Choose not to disclose ◯ Other:

Guarantor/Responsible Party (If different from patient)			
If a legal guardian, court documentation must be provided			
Last Name:	First Name:	MI:	
Relation to Patient:	DOB:		
Address:	City:	State:	Zip Code:
Email:	Phone Number (☐ Cell ☐ Home):	Work Phone:	

Emergency Contact Information

	Emergency Contact 1	**Emergency Contact 2**
Name		
Relation		
Address		
City, State, Zip		
Phone Number		

Insurance Information		
Primary Insurance:	Policy's Holder (*if different from patient*):	
Policy Holder's DOB:	Relationship to Patient:	
Group Number:	Policy Number:	Effective Date:
Secondary Insurance:	Policy's Holder (*if different from patient*):	
Policy Holder's DOB:	Relationship to Patient:	
Group Number:	Policy Number:	Effective Date:
Dental Insurance:	Policy's Holder (*if different from patient*):	
Policy Holder's DOB:	Relationship to Patient:	
Group Number:	Policy Number:	Effective Date:

Preferred Pharmacy

Name	City

Contacting You

Tell us where to call you, leave you messages and appointment reminders: ☐ Home ☐ Cell ☐ Work

Can BRMC/BRDC leave messages on the phone numbers you have provided? ○ Yes ○ No

If yes, we may leave:

Brief messages with no clinical information, *OR* ○ Yes ○ No

Extended messages with some clinical information ○ Yes ○ No

Demographic Information

As a medical center that receives some federal funding, the following information will help us tailor our services to better meet your needs and to obtain grants and other funds to continue improving our practice. THANK YOU in advance for your assistance.

Race (select all that apply):

☐ Black/African American	☐ White	☐ Native Hawaiian	☐ Chinese
☐ Filipino	☐ Japanese	☐ Korean	☐ Native American/Alaskan
☐ Asian Indian	☐ Vietnamese	☐ Other Asian	☐ Guamanian
☐ Chamarro	☐ Samoan	☐ Other Pacific Islander	☐ More than one race

☐ Choose not to disclose

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Choose not to disclose

If Hispanic:

☐ Argentino	☐ Colombian	☐ Cuban	☐ Peruvian
☐ Mexican	☐ Mexican-American	☐ Chicano	☐ Puerto Rican
☐ Guatemalan	☐ Honduran	☐ Salvadorian	☐ Venezuelan
☐ Another Hispanic/Latino/Spanish Origin		☐ Choose not to disclose	

Primary Language:	**Would you need an Interpreter?** ○ Yes ○ No

Are you a veteran? ○ Yes ○ No

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Housing:
○ Single Family ○ Multi-Family ○ Apartment ○ Other:

Are you experiencing homelessness? ○ Yes ○ No

If Yes, where are you staying?
○ Street ○ Transitional Housing ○ Doubling Up
○ Homeless Shelter ○ Unknown ○ Other:

Employment:
○ Full-time ○ Part-time ○ Retired ○ Student ○ Other:

Employer Name: **Employer Address:**

Are you a seasonal or migrant worker?
○ Migrant ○ Seasonal ○ Neither

Household Size:

Annual household Income:
○ **$** ○ Decline to state

Do you have an Advance Directive on File with our Office? ○ Yes ○ No

Would you like information about Advance Directive? ○ Yes ○ No

How did you hear about Blue Ridge Medical Center?
☐ Family/Friend ☐ Internet ☐ Newspaper
☐ Social Media ☐ Radio/TV/Billboard ☐ Other:

Please read the item below and initial beside each item, then sign and date as noted	Initials
PRIVACY PRACTICE: I have read and understand the BRMC/BRDC "Notice of Privacy Practices."	
MEDICAL RECORDS: I give permission to BRMC/BRDC to obtain medical records from any provider, practice, or pharmacy where I have received services to optimize my care.	
INSURANCE: I authorize BRMC/BRDC to furnish information to my insurance company regarding my health or healthcare or dental care. I have assigned BRMC/BRDC to receive payment from insurance claims filed by BRMC/BRDC for medical/dental services. I understand that I am responsible for the payment of all fees and that I am ultimately responsible for making sure my insurance will cover appointments with BRMC/BRDC and with specialists to whom I am referred by BRMC/BRDC.	
PATIENT PAYMENT RESPONSIBILITY: I understand that I am responsible for payment for services received at BRMC/BRDC, whether full fee, nominal fee or sliding scale. Insured patients acknowledge responsibility for co-pays, deductibles, and co-insurance payments. All unpaid balances are subject to collections fees.	
AUTHORIZATION TO TREAT: I Authorize BRMC/BRDC to treat me for the conditions for which I present to the center.	

Patient/Guardian Signature: **Date:**

Please have your insurance card available at check in. The Front Desk representative will take your photograph so that we can accurately identify you at each visit. The photo is for internal use only

FOR OFFICE USE ONLY					
Entered: Yes No	**Date:**	**Initials:**	**Scanned:** Yes No	**Date:**	**Initials:**

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Privilege to Discuss / HIPAA Consent Form

Patient Name: ____________________ **DOB:** __________ **Date:** __________

Please list all individuals with whom we may discuss your medical care.

Name: ____________________ **Relationship**: ______________ **Phone**: ______________

☐ Authorization to discuss **Medical Information** ☐ Authorization to discuss **Billing Information** ☐ Authorization to **Schedule Appointments** on patient behalf

Name: ____________________ **Relationship:** ______________ **Phone:** ______________

☐ Authorization to discuss **Medical Information** ☐ Authorization to discuss **Billing Information** ☐ Authorization to **Schedule Appointments** on patient behalf

Name: ____________________ **Relationship:** ______________ **Phone**: ______________

☐ Authorization to discuss **Medical Information** ☐ Authorization to discuss **Billing Information** ☐ Authorization to **Schedule Appointments** on patient behalf

Name: ____________________ **Relationship**: ______________ **Phone**: ______________

☐ Authorization to discuss **Medical Information** ☐ Authorization to discuss **Billing Information** ☐ Authorization to **Schedule Appointments** on patient behalf

By signing this form, I understand that **1)** The disclosing provider, along with its employees, agents, and volunteers, are hereby released from any legal responsibility regarding the disclosure of the above information to the extent indicated and authorized herein. Furthermore, it is understood that the recipient may re-disclose this information, thereby forfeiting the protection provided by law, **2) I** may revoke my consent at any time, in writing.

______________________________ Patient/Guardian Signature

______________________________ Date

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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL AND BEHAVIORAL PROTECTED HEALTH INFORMATION

Patient Name: ______________________ **DOB:** ____________ **SSN (last 4 digits)** ______

Patient Address: ____

Primary Phone Number: ______________ **Cellphone Number:** ______________

Person Giving Consent: ____________ **Relationship to Patient:** ☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney

I hereby authorize Blue Ridge Medical Center to use and (please choose one of the following):

☐ DISCLOSE TO (to give records to another facility)	☐ OBTAIN FROM (to have records sent to BRMC)

In what format would you like your records? ☐ FAX ☐ PICKUP ☐ ELECTRONIC (CD)

Facility: ____

Facility Address: ____

Telephone Number: ______________________ **Fax Number:** ______________________

For the following dates requested (required): ______________ **through:** ______________

Primary Care (Check All that apply)				Behavioral Health (Check All that Apply)		Dental (Check All that Apply)	
	All Records		Office Notes		Assessments		Office Notes
	Immunizations		Imaging Reports		Mental health diagnoses		Medication List
	Lab Results		Billing Reports		Office Notes		Billing Report
	Medication List		Other:		Other:		Other:

I authorize the exchange of information requested for the following purposes(s) (please choose one of the following):

☐ INSURANCE ☐ LEGAL ACTION ☐ TRANSFER OF CARE ☐ CONTINUED TREATMENT ☐ PERSONAL USE ☐ EDUCATION

☐ OTHER: (Specify): ____

Unless the format of records is indicated specifically above, the above information may be shared verbally, or in written or electronic form. I understand that information disclosed pursuant to this authorization may be released or distributed by the recipient and may no longer be protected by HIPAA. Sensitive records, such as those related to mental health, alcohol abuse or substance abuse treatment, HIV/STDs may be included in the release of records/information. Except to the extent that Blue Ridge Medical Center or other lawful holder of my records has already acted in reliance upon it, this authorization is subject to revocation at any time by sending a written request to Blue Ridge Medical Center, Release of Information, Attn: Privacy Officer, 4038 Thomas Nelson Hwy, Arrington VA 22922. ***Otherwise, this authorization will automatically expire upon within one year from the signed date below.***

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. A copy of this authorization and a notification concerning the person or agencies to whom disclosure was made shall be included with my original health record. I may refuse to sign this form. I understand that Blue Ridge Medical Center will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the provision of this authorization.

NOTICE TO RECIPIENT OF RECORDS: The information has been disclosure to you from records protected by Federal Regulations (42 CFR Part 2) which prohibits a recipient from making any further disclosure of this information in this record that identifies a patient as having had a alcohol or substance use disorder either directly, by reference to publicly available information, or though verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at #2.21© (5) and 2.65.

______________________________ ______________
Patient's or Authorized Representative's Printed name Date

______________________________ ______________
Patient's or Authorized Representative's Signature Date

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor:	**Date of last exam:**

Specialist's name and location (cardiologist, dermatologist etc.):

Tobacco use: ☐ Yes ☐ No	**Alcohol use:** ☐ Yes ☐ No

PERSONAL HEALTH HISTORY

Childhood illness:
☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus/Tdap	☐ Pneumonia
	☐ COVID	☐ COVID Booster
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Have you ever been told by a Medical Doctor that you have any of the following conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Congenital heart disease			Transient Ischemic Attack (TIA)			Sexually transmitted Disease			Skin Cancer		
									Breast Cancer		
Heart Attack/ Myocardial Infarction			Coagulation Disorders/Bleeding Problems			Women- Abnormal Pap Smear			Prostate Cancer		
									Cancer, other		
Hypertension/High Blood Pressure			Alcohol Abuse			Urinary Incontinence			Ovarian Cancer		
Diabetes Mellitus/ Sugar (Type 2)			Thyroid Disease			Birth Defects			Migraines/ Headaches		
Glaucoma			Hay fever			Hearing Problems			Mental Disability		
Kidney Disease			Lupus			Osteoporosis			Arthritis		
Diabetes: Type 1			Eczema			Asthma			Anemia or Blood Disorder		
High Cholesterol			Epilepsy/ Seizures			Rheumatoid Arthritis					
Depression/Anxiety			Environmental Allergies			BPH					

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandmother** *Maternal*			
	☐ M ☐ F			**Grandfather** *Maternal*			
	☐ M ☐ F			**Grandmother** *Paternal*			
	☐ M ☐ F			**Grandfather** *Paternal*			

______________________________ ______________________________
Patients Name (Printed) **Date**

____
Patients Signature

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Patient No Show Agreement

Thank you for choosing Blue Ridge Medical Center for your health care needs. At our Center, you can expect caring professionals to provide you with the highest quality care.

Patients at our Center have rights and responsibilities. These lists are part of the registration packet, and are posted in various places in the building.

A very important patient responsibility is to keep your appointment, and to arrive on time. This helps us to give you good care and keeps access open for others in the community who also need to be seen.

Please take some time to read through the following statements and indicate that you understand them. If you have any questions, please ask at the front desk. We will be glad to explain further.

Thanks again!

1. I understand that if I no-show or cancel an appointment with a notice of less than one full business day, the appointment can only be rescheduled with provider approval. _____ Initial

2. I understand that if I have three no-show appointments within 24 months, I will be notified that I will only be able to schedule same day appointments. Any additional missed appointment after this documented conversation occurs will result in discharge from the practice. _____ Initial

3. Pediatric no shows will be reviewed by the pediatric providers for further scheduling guidance. _____ Initial

4. I understand that I should arrive for an appointment at least 15 minutes before the scheduled time with my provider; and that if I arrive after my appointment time, the provider will decide whether I will need to reschedule. _____Initial

_________________________________ _________________________________

Patient Name (Printed) Date of Birth

_________________________________ _________________________________

Signature (Patient / Guardian) Date

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BRMC Website Access Form

If you would like to view your Personal Health Information online, please complete this form and hand it to the Front Office Staff. We will send you a computer-generated e-mail with your personal username and password.

Name: ______________________ Date of Birth: _____________

Yes, I would like to be added as a user of the Patient Health Website.

Please use this e-mail address* __________________________________ to send me my **username** and **password** for the BRMC Personal Health Information Website.

Signature: ____________________ Today's Date: ______________

Please complete the information below to link information for your minor children (add the names and dates of birth for your minor children to enable access to the children's accounts). If your spouse or significant other would also like access, please have him/her complete the additional form on the back of this page. (Note: When your child turns 18, only he/she will have access to their personal health information.)

Child 1 _____________________________ Date of Birth _________________

Child 2 _____________________________ Date of Birth _________________

Child 3 _____________________________ Date of Birth _________________

Child 4 _____________________________ Date of Birth _________________

Child 5 _____________________________ Date of Birth _________________

*e-mail is required for online interaction.

For office use only

Date Received: _________

Returned by: __________

BRMC Staff: __________

BLUE RIDGE MEDICAL CENTER

4038 Thomas Nelson Highway, Arrington, VA 22922
Phone: 434-263-4000 Fax: 434-263-4160 Email: slide@brmedical.com

APPLICATION FOR FINANCIAL ASSISTANCE - SLIDING SCALE PROGRAM

APPLICATIONS WILL NOT BE PROCESSED ON THE DAY OF SERVICE!
Applications without proof of all Income or Support will NOT BE PROCESSED!
(See back for instructions.)

Name: ______________________ SSN: ______________ Birth Date: ______________

Mailing Address: ______________________________ City: __________ State: _______ Zip: _______

Physical Address: ______________________________ City: __________ State: _______ Zip: _______

Email Address: ______________________________

Telephone #: Home: ______________ Cell: ______________ Work: ______________

"***Family/Household***" includes the Applicant and dependents** (as defined by IRS), ***AND*** any SPOUSE / PARTNER / FIANCE in the home.
** If someone claims you as a dependent, then list all other family members.

Family/Household members: *If more space is needed, attach a separate sheet.*	Date Of Birth	Relationship To Applicant	Monthly Gross Income: *PROOF is required (See Back)*	Employer Name (if employed) or Source of Income	Full Time Student? Yes/No	Race (ie: White, Asian, African American, Native American, etc.)
		Self				

How many are in your family/household? ________ If Unemployed, date employment ended: ______________

Applicant: How often are you paid? __________ Date Employment Began: __________ Employer Phone No.: __________

Other: How often are you paid? __________ Date Employment Began: __________ Employer Phone No.: __________

If you have NO, or VERY LOW, income ***PROVIDE PROOF*** of how you are supported? ______________________________

PROVIDE ***PROOF*** / DOCUMENTATION of any of the following as well:

Food Stamps: Yes / No Amount: $	Unemployment wages: Yes / No Amount: $
Child Support: Yes / No Amount: $	Disability: Approved or pending Yes / No Amount: $
Spousal Support: Yes / No Amount: $	Do you *Receive* rental income? Yes / No Amount: $

Do you or others in the household have health insurance? Yes / No Name(s): ______________ Insurance? ______________
(including Medicare or Medicaid) Name(s): ______________ Insurance? ______________

DECLARATION: The information provided above is, to the best of my knowledge and belief, complete, accurate and true. I understand that if I give false information, withhold information, or fail to report changes in my income, I will be disqualified from this program; and could be prosecuted for perjury, larceny, and/or fraud. I authorize the release of all information which Blue Ridge Medical Center may need to determine whether I qualify for financial assistance through the Sliding Scale Program.

Applicant **Signature**:	Date:
Other adult and/or Partner Signature: (see # 3 on Reverse)	Date:

Office Use Only (below this line)

BRMC: Income: ____________ S.S. Status: _____ Eff. Dates: ______________ Migrant? ______ Date/Init.: ________

BLUE RIDGE MEDICAL CENTER

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Applications without proof of ALL Income or Support WILL NOT BE PROCESSED!

Blue Ridge Medical Center Pharmacy charges and charges for some Dental procedures and services are exempt from the Sliding Scale. However, some discounts may apply for eligible patients. Eligibility will be based on information supplied in this application.

1. **Fill in every blank field and** ***ATTACH PROOF OF ALL INCOMES***. If no income, see "UNEMPLOYED - NO INCOME", below. Incomplete applications & applications missing income documentation/support ***will*** be returned and significantly delay processing. **You will be expected to pay full fee for charges until your application is complete.**

2. **Other Adults in home**: If you are a spouse/partner/boyfriend/girlfriend/partner/fiancé, or otherwise "significant other", in the home, ***proof*** of your income is REQUIRED. If you are an adult "**dependent**" – see #3.

3. **"Other Adult and/or Partner" -** Please sign this application if you live in the home and wish to be considered for this program **AND** you are either:
   - An adult child of the applicant. (**Dependent adult children must provide PROOF of dependence – IRS 1040**); OR
   - An unmarried partner (fiancé, girlfriend, boyfriend) of the applicant.

The following types of documentation are required, as applicable, to document your income:

- **EMPLOYED**:
  - If employed during total of previous tax year, then the prior year's IRS 1040 Income Tax Return, or
  - 1 month's worth of **CURRENT** pay stubs showing gross income, or
  - A letter from your employer stating 1 current month's gross salary
- **SELF EMPLOYED**: Prior year's Federal Income Tax return (IRS 1040), along with Schedule C
- **UNEMPLOYED – LOW/NO INCOME:** Written statement from family or friend verifying financial support and lack of income &/or employment.
- **UNEMPLOYMENT/WORKER'S COMPENSATION:** Documentation verifying weekly benefit amount, or Denial
- **GOVERNMENT BENEFITS**: Social Security, SSI, VA, Disability, or other government benefits
  - Social Security Letter confirming or denying, and listing monthly gross amount (Bank statement can **NOT** be used)
  - IRS 1099 showing yearly amount (if received for total year)
- **SOCIAL SERVICES:**
  - SNAP "Notice of Action" for Food Stamps, Aid to Dependent Children, TANF, Housing, etc.
- **OTHER RESOURCES**: Provide legal proof, or official award letter
  - Retirement benefits
  - Trust fund allotments
  - Child Support and/or Alimony – received only
- **HOMELESS:** Letter from shelter, if client is homeless
- **LIQUID ASSETS**: Provide statement(s) from Bank or Credit Union
  - Investments, CD'S, Interest, Dividends
- **OTHER:** As appropriate **-** Copy of custody papers for dependents listed, if income is too low to file taxes.

Comments: ***You may use this area to explain any unusual circumstances which you feel may be helpful.***

Telemedicine: What to Expect

Your provider at Blue Ridge Medical Center is offering telemedicine services in the time of national public health emergency related to COVID 19.

What is Telemedicine?

Telemedicine is the exchange of medical information from one site to another via electronic communications. The telemedicine service offered to you will allow you to have a medical appointment with your health care team via secure and interactive video equipment or audio equipment, i.e. telephone. You will be able to speak in real-time with the provider during your telemedicine appointment.

Is Telemedicine Safe?

Yes, all telemedicine sessions are safe, secure, encrypted, and follow the same p1ivacy (i.e., HIPAA) guidelines as traditional, in-person medical appointments. Your telemedicine appointments will always be kept confidential. In addition, telemedicine appointments are NEVER audio or video recorded.

Can I Choose Not to Participate?

Of course, with this you have been offered an alternative format of care during this time of national public health emergency. It is your choice to receive services by way of videoconferencing or audioconferencing.

Things to Remember about Your Telemedicine Appointment:

1. You will schedule your telemedicine appointments the same way you schedule an appointment with your doctor now, by calling 434-263-4000.
2. As with your traditional, in-person medical appointments it is your responsibility to call Blue Ridge Medical Center at 434-263-4000 to cancel an appointment if you are unable to attend your telemedicine appointment.
3. Cancelations should be made at least 24 hours prior to the appointment time.
4. On the day of your appointment, you will either be available by telephone at the designated number provided during scheduling or by video on your Healow application.
5. At your appointment time a nurse or medical assistant will connect with you to review your health history and medications
6. If you have any questions before or after the session, you may ask the office staff at Blue Ridge Medical Center.
7. If you are presc1ibed medication(s) by the provider, you will be able to pick it up directly at your pharmacy of choice as the provider will either phone in or electronically prescribe your medication(s).

If you have any questions or concerns after reading this form, please contact:

Blue Ridge Medical Center at 434-263-4000

Patient Name: ____________________________ DOB: ______________________________

Telemedicine Consent Form

Patient's Name: ____________________________ **DOB:** _______________ **Date:** ______________

1. ___ I authorize **Blue Ridge Medical Center** to allow me/the patient to participate in an alternative delivery of care to face-to-face services in the time of national public health emergency related to COVID 19. I agree to participate by way of telephone (audioconferencing), or telemedicine (videoconferencing) services provided through **eClinicalWorks**, **Healow App**, **doxy.me** and/or **Doximity**.
2. ___ I understand that this service is not the same as a direct patient healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be postponed until a later time or recommend additional follow up as guided by the servicing medical provider.
3. ___ My/the patient's provider has fully explained to me the nature and purpose of the audioconferencing or videoconferencing technology and has also informed me of expected risks, benefits, and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The attendant risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
4. ___ I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telemedicine service if we believe that the videoconferencing connections are not adequate for the situation.
5. ___ I understand that the telemedici.ne session will not be audio or video recorded at any time.
6. ___ I agree to permit my/the patient's healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telemedicine service to operate the video equipment, if necessary. I further understand that I will be infom1ed of their presence during the telemedicine services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.
7. ___ I acknowledge that I have the right to request the following:
    a. Asking non-medical personnel to leave the telemedicine room at any time if not mandated for safety concerns, or
    b. Termination of the service at any time.
8. ___ When the telemedicine service is being used during an emergency, I understand that it is the responsibility of the telemedicine provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.
9. ___ It is the responsibility of the telemedicine provider to conclude the service upon termination of the audioconference or video conference connection.

10. ___ The patient understand(s) that my/the patient's insurance will be billed by **Blue Ridge Medical Center** for audioconferencing or videoconferencing as telemedicine services. I the patient understand(s) that if my insurance does not cover telemedicine services I/the patient will be billed directly.
11. ___ My/the patient's consent to participate in this telemedicine service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
12. ___ I the patient agree that there have been no guarantees or assurances made about the results of this service.
13. ___ I confirm that I have read and fully understand both the above and the **Telemedicine: What to Expect** form provided. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

______________________________	______________________________
Patient/Relative/Guardian Signature	Print Name
______________________________	______________________________
Relationship to Patient (If required)	Date
______________________________	______________________________
Witness	Date
______________________________	______________________________
Interpreter (If required)	Date

*** The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.**

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PATIENT RIGHTS

As a patient of Blue Ridge Medical Center, you have the right to:

1. You have the right to know about your illness, treatment, and what might happen later. This information will be given to you by providers and other medical staff in a language you can understand.
2. You have the right to make decisions about your treatment. You have the right to know why you need care or treatment and who will perform that care or treatment.
3. You have the right to refuse care or treatment and to know what may happen if you do not have this treatment.
4. You have the right to know the name of the provider who oversees your care. You also have the right to know the names of all other medical center staff taking care of you.
5. You have the right to have all information about your illness and care treated as confidential.
6. You have the right to review your bill and ask questions you may have about it.
7. You have the right to access your medical and billing records.
8. You have the right to agree or refuse to take part in any study or experiment related to your care or treatment.
9. Health care is best when there is an open, trusting, and helpful relationship between you and the people taking care of you. We will make every effort to see that you receive the best care we can give.
10. We would like to know if you have any concerns about your treatment, care or safety. Please discuss them with your medical care provider, nurse, or the Chief Executive Officer.

4038 Thomas Nelson Hwy, Arrington, VA 22922 ● Ph: 434.263.4000 ● Fax: 434.263.4160

PATIENT RESPONSABILITIES

As a patient of Blue Ridge Medical Center, we respectfully request that you:

1. Arrive on time for your appointments
2. Cancel appointments that you cannot keep.
3. Provide all information necessary for billing and insurance processing.
4. Be respectful of the property of other persons and of BRMC.
5. Be considerate of other patients and BRMC personnel.
6. Adhere to the BRMC "no weapons" on the property policy.
7. Control noise and language
8. Extinguish any smoking materials. (BRMC is a smoke-free facility. This includes the entire property.)
9. Bring your medications with you to each visit.
10. Communicate your care needs and concerns to your medical care provider.
11. Be an active participant in determining your plan of care with your healthcare provider.
12. Follow your plan of care and take responsibility for your actions if you refuse to follow the treatment plan.
13. Understand and meet your financial obligations to Blue Ridge medical Center.
14. Let the Chief Executive Officer know or fill out a patient suggestion form if you would like to share thoughts, feelings or concerns about your care or our service.

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Advanced Medical Directives

Your Right to Decide and Communicating Your Health Care Choices

Blue Ridge Medical Center supports your right to make decisions about your own medical care now and in the future. It is important that you clearly communicate your wishes regarding your care to your medical care provider so they can be considered for all aspects of your care at Blue Ridge Medical Center.

In 1990, Congress passed the **Patient Self-Determination Act** that requires health care facilities to tell patients and the community about their right to make decisions about their medical care. These rights include the right to accept or refuse care and the right to create Advance Medical Directives.

We never know when a serious illness will leave us incapable of making our own health care decisions. For peace of mind, it is important to think about and talk about your values and wishes for medical care with your loved ones and to put these wishes in writing.

An **Advance Medical Directive** is a written plan that expresses your decisions about your health care if you become unable to make your own health care decisions.

Concerning the **Life Prolonging Treatment** portion of your Advance Medical Directive, Blue Ridge Medical Center will stabilize you/the patient and transfer care to a hospital. A copy of your/the patient's Advance Medical Directive will accompany you/the patient.

Ask your medical provider for more information if you do not have an Advance Medical Directive on file with Blue Ridge Medical Center. Your provider or nurse can give you more information and help you complete the necessary documents.

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Effective September 1, 2013

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you as a patient of Blue Ridge Medical Center may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will place a copy of our current Notice on the tables in our lobby at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Executive Director, Blue Ridge Medical Center, Phone: 434-263- 4000, 4038 Thomas Nelson Highway, Arrington, VA 22922

C. We may use and disclose your information {PHI) in the following ways:

1. **Treatment.** Our practice may use your information {PHI) to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your information (PHI) in order to write a prescription for you, or we might disclose your information (PHI) when we order a prescription for you. Many of the people who work for our practice -including, but not limited to, our doctors and nurses -may use or disclose your information (PHI) in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your information (PHI) to other health care providers for purposes related to your treatment.
2. **Payment.** Our practice may use and disclose your information (PHI) in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your information (PHI) to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your information (PHI) to bill you directly for services and items. We may disclose your information (PHI) to other health care providers and entities to assist in their billing and collection efforts.
3. **Health care operations.** Our practice may use and disclose you information (PHI) to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the

quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your information (PHI) to other health care providers and entities to assist in their health care operations.

4. **Appointment reminders, treatment options and Health-related benefits and services**. Our practice may use and disclose your information (PHI) to contact you and remind you of an appointment. Our practice may use and disclose your information (PHI) to inform you of potential treatment options or alternatives. Our practice may use and disclose your information (PHI) to inform you of health-related benefits or services that may be of interest to you.
5. **Release of information to family/friends**. Our practice may release your information (PHI) to a friend or family member who is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
6. **Disclosures required by law.** Our practice will use and disclose your information (PHI) when we are required to do so by federal, state, or local law.

D. Use and disclosure of your information (PHI) in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public health risks.** Our practice may disclose your information (PHI) to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths,
    - Reporting child abuse or neglect,
    - Preventing or controlling disease, injury or disability,
    - Notifying a person regarding potential exposure to a communicable disease,
    - Notifying a person regarding potential risk for spreading or contracting a disease or condition,
    - Reporting reactions to drugs or problems with products or devices,
    - Notifying individuals if a product or device they may be using has been recalled,
    - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health oversight activities**. Our practice may disclose your information (PHI) to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and similar proceedings**. Our practice may use and disclose your information (PHI) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your information (PHI) in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law enforcement.** We may release information (PHI) if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if, we are unable to obtain the person's agreement,
    - Concerning a death we believe has resulted from criminal conduct,
    - Regarding criminal conduct at our offices, In response to a warrant, summons, court order, subpoena or similar legal process,
    - To identify/locate a suspect, material witness, fugitive or missing person,
    - In an emergency, to report a crime [including the location of victim(s) of the crime, or the description, identity or location of the perpetrator].
5. **Deceased patients.** Our practice may release information (PHI) to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We also may release information in order for funeral directors to perform their jobs.
6. **Organ and tissue donation.** Our practice may release your information (PHI) to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. **Research.** Our practice may use and disclose your information (PHI) for research purposes in certain limited circumstances. We will obtain your written authorization to use your information (PHI) for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
    a) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the

earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

b) The research could not practicably be conducted without the waiver,

c) The research could not practicably be conducted without access to and use of the PHI.

8. **Serious threats to health or safety.** Our practice may use and disclose your information (PHI) when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your information (PHI) if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National security.** Our practice may disclose your information (PHI) to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your information (PHI) to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' compensation.** Our practice may release your information (PHI) for workers' compensation and similar programs.

E. Your rights regarding your information (PHI):

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Executive Director, Blue Ridge Medical Center, 4038 Thomas Nelson Hwy, Arrington, VA 22922, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your information (PHI) for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your information (PHI) to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are bound by the restrictions that you request except when otherwise required by law, in emergencies or when the information is necessary to treat you. Further, we engage in fundraising activities for which you may be contacted. However you have the right to opt-out of these communications. You have the right to request a restriction on certain disclosures if the disclosure is purely for carrying out payment or healthcare operations for services that you have paid for in full. In order to request a restriction in our use or disclosure of your information (PHI), you must make your request in writing to: **Executive Director, Blue Ridge Medical Center, 4038 Thomas Nelson Highway, Arrington, VA 22922.** Your request must describe in a clear and concise fashion: 1) The information you wish restricted, 2) Whether you are requesting to limit our practice's use, disclosure or both, and 3) To whom you want the limits to apply.
3. **Inspection and copies.** You have the right to inspect and obtain a copy of the information (PHI) that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Medical Records Supervisor, Blue Ridge Medical Center 4038 Thomas Nelson Highway, Arrington, VA 22922, in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Medical Records Supervisor, Blue Ridge Medical Center 4038 Thomas Nelson Highway, Arrington, VA 22922. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; {b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented -for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Medical Records Supervisor, Blue Ridge Medical Center 4038 Thomas Nelson Highway, Arrington, VA 22922. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact anyone at our office.
7. **Right to an electronic copy of this notice.** Most Blue Ridge Medical Center Protected Health Information is maintained in an electronic format (electronic health record). You have the right to request that an electronic copy be given to you or transmitted to another individual or entity. We will make every effort to provide access in the form or format you request, if it is readily producible. If the record is not readily producible in the form or format you request your record will be provided in either our standard electronic format or we will provide a readable hard copy. We may charge you a reasonable, cost-based fee for the labor associated with the electronic medical record.
8. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: Executive Director, Blue Ridge Medical Center 4038 Thomas Nelson Highway, Arrington, VA 22922. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
9. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain a separate written authorization for disclosure of psychotherapy notes, use or disclosure of Protected Health Information for marketing purposes, disclosure that constitutes the sale of Protected Health Information and for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your information (PHI) may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care. Again, if you have questions regarding this notice or our health information privacy policies, please contact the Executive Director at 434-263-4000.
10. **Blue Ridge Medical Center is required to notify affected individuals of breaches to their unsecured PHI.**

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