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	Forms you must complete
Privilege to discuss/HIPAA Consent Form	Forms you must complete
Request for Medical Records	Forms you must complete
Health History Questionnaire	Forms you must complete
No Show Policy	Forms you must complete
Integrated Virtual Care Consent Form	Forms you must complete
Patient Responsibilities	Forms you must complete
Financial Assistance (If Applicable)	Optional forms for services
Patient Rights	Yours to keep
Notice of Privacy Practices	Yours to keep

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

Blue Ridge MEDICAL CENTER

4038 Thomas Nelson Hwy ● Arrington, VA ● 22922 ● 434.263.4000

Patient Registration Form

Registration is for ☐ Medical (BRMC) ☐ Dental (BRDC) ☐ Both Date: _____

Patient Information			
Last Name:	First Name:	MI:	Sex Assigned at Birth: ☐ M ☐ F
Address:			DOB:
City:	State:		Zip Code:
Cell Phone:			
Home Phone:	Work Phone:		
Email:			SSN:
Would you like access to your patient portal and Healow app to view visits, lab results, personal information, messages, and online services (*You can request to be opt out at any moment*)? ☐ Yes ☐ No			

Communication Preferences
Which phone number should we use for appointment reminders and messages? ☐ Cell ☐ Home ☐ Work
How would you prefer to receive appointment reminders? ☐ Text ☐ Voice Call ☐ Either
May BRMC/BRDC leave messages on the phone numbers you have provided? ☐ Yes ☐ No **If yes, what type of messages may we leave?** ☐ Brief messages only (no clinical information) ☐ Detailed messages (may include limited clinical information)

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		
DOB		
Address		
City, State, Zip		
Phone Number		

Insurance Information

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

Preferred Pharmacy

Name	City

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.

Gender Identity:

☐ Male ☐ Female ☐ Transmasculine
☐ Transfeminine ☐ Choose not to disclose ☐ Other: _____

Race (select all that apply):

☐ Black/African American ☐ White ☐ Native American/Alaskan ☐ Asian Indian
☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro
☐ Samoan ☐ Other Pacific Islander ☐ More than one race ☐ Choose not to disclose

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

If Hispanic:

☐ Mexican ☐ Mexican-American ☐ Chicano ☐ Puerto Rican
☐ Cuban ☐ Another Hispanic/Latino/Spanish Origin ☐ Choose not to disclose

Primary Language: ◯ English ◯ Spanish
Other: _____

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?

○ Homeless Shelter ○ Transitional Housing ○ Doubling Up

○ Street ○ Permanent Supportive Housing ○ 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 acknowledge that I have been informed of BRMC/BRDC's Notice of Privacy Practices and offered a copy.	
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 provide 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:**

Blue Ridge MEDICAL CENTER

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Privilege to Discuss / HIPAA Consent Form

Patient Name: _____ **DOB:** _____

Please list all individuals with whom we may discuss your medical care. We will not discuss your medical care with anyone NOT listed below

Name: _____ DOB: _____

Relationship: _____ Phone: _____

O Authorization to discuss Medical/Dental Information

O Authorization to discuss Billing Information

O Authorization to Schedule Appointments on patient behalf

Name: _____ DOB: _____

Relationship: _____ Phone: _____

O Authorization to discuss Medical/Dental Information

O Authorization to discuss Billing Information

O Authorization to Schedule Appointments on patient behalf

Name: _____ DOB: _____

Relationship: _____ Phone: _____

O Authorization to discuss Medical/Dental Information

O Authorization to discuss Billing Information

O 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

Blue Ridge MEDICAL CENTER

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AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL AND BEHAVIORAL PROTECTED HEALTH INFORMATION

Patient Name: _____ **Previous Name:** _____

DOB: _____ **SSN (Last 4 digits):** _____

Patient Address: _____

Phone Number: _____ **Cellphone Number:** _____

Person Giving Consent: _____ **Relationship to Patient:** _____

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

☐ DISCLOSE (to give records to another facility) ***Or*** ☐ OBTAIN (to have records sent to BRMC)

the following Personal Health Information:

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

For the following dates: ☐ 2 Years Or From: _____ To: _____

From/To the following facility:

Facility Name: _____ **Fax:** _____

Facility Address: _____ **Phone Number:** _____

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

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

☐ INSURANCE	☐ LEGAL ACTION	☐ TRANSFER OF CARE/CONTINUED TREATMENT	☐ OTHER:

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 regarding 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 Signature **Date**

_____ _____

Individual who assisted in completing the form **Date**

Blue Ridge MEDICAL CENTER

HEALTH HISTORY QUESTIONNAIRE

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

Patient Name:	☐ M ☐ F	**DOB:**
Previous or referring doctor:		**Date of last exam:**
Specialist's name and location (cardiologist, dermatologist etc.):		

PERSONAL HEALTH HISTORY

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

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

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

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*			

Patient /Guardian Signature **Date**

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Patient No Show Agreement

Name: _____ **DOB:** _____

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's 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 cancelling a visit with less than 24 hours' notice is considered a no-show.

   Initials_____

2. I understand that if I have three no-show appointments within 24 months, I will be suspended until I have met with the community health worker and/or designee and develop a written action plan. Failure to adhere to the action plan may result in discharge from the practice.

   Initials_____

3. I understand that if I arrive for an appointment more than 10 minutes late, I will not be able to have my appointment, and this will be considered a no-show.

   Initials _____

_____ _____

Patient/Guardian Signature Date

Blue Ridge MEDICAL CENTER

Consent for Integrated Virtual Care

Patient Name: _____ **DOB:** _____

Blue Ridge Medical Center offers integrated virtual care services using secure audio and/or video technology, including platforms such as Healow, eClinicalWorks, Patient Portal, Doxy.me, Doximity, telephone communication, remote patient monitoring systems, and other approved systems. Integrated virtual care services may include telemedicine, follow-up care, behavioral health services, medication management, patient education, remote monitoring of patient health information, AI-assisted clinical documentation and scribing, and approved AI toolsets that support care coordination and operational workflows.

AI tools are used to support, not replace, medical decision-making by licensed healthcare professionals, and all diagnoses, treatment decisions, and patient care remain the responsibility of the healthcare provider. Any AI-supported tools used by Blue Ridge Medical Center follow applicable privacy, security, and confidentiality standards.

I understand and agree that:

- Integrated virtual care, including telemedicine and remote monitoring, is different from an in-person visit because the provider and patient may not be in the same location and some information may be collected or reviewed remotely.
- Certain medical conditions may require an in-person visit, examination, testing, or treatment.
- Technical problems, device issues, connectivity interruptions, or remote monitoring data transmission issues may occur during or between virtual care services.
- My health information will remain part of my confidential medical record and protected under HIPAA and applicable privacy laws.
- Telehealth visits and AI-supported services are not routinely audio or video recorded unless otherwise disclosed and authorized.
- Participation in integrated virtual care services, including telemedicine and remote monitoring, is voluntary, and I may stop or refuse these services at any time.
- Integrated virtual care services may be billed to my insurance similarly to in-person visits, when applicable.

By signing below, I acknowledge that:

- I have read and understand this form.
- I consent to receive integrated virtual care services from Blue Ridge Medical Center, including telemedicine, Patient Portal Access and remote patient monitoring when appropriate.
- I acknowledge and consent to the use of approved AI-assisted technologies as described above, including AI scribing and AI toolsets used to support documentation, workflow, communication, and care coordination.
- I understand that I may revoke this consent at any time by notifying Blue Ridge Medical Center.

_____ _____

Patient/Guardian Signature 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 Responsibilities

Patient Name: _____ **Patient DOB:** _____

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

Respect and Dignity: Patients must treat all Blue Ridge Medical Center (BRMC) employees, its affiliates, and other patients with respect and dignity at all times. BRMC will not tolerate any form of aggression or verbal harassment towards anyone for any reason. Unacceptable behavior may result in removal from facility, dismissal from our practice and legal action and/or arrest.

Appointments: Patients have a responsibility to attend their scheduled appointments and arrive on time as instructed. Must bring the following: appropriate forms of ID, documentation of legal responsibly or guardianship of the patient (if applicable), current insurance card(s), medications, and be prepared to pay the required co-pay for the visit (consider making payment on any outstanding balances). If for any reason you cannot attend your appointment, you must provide a minimum of 24-hour advance notification. Patients must review, sign and adhere to the No-Show policy document.

Insurance Coordination: Patients are responsible for responding to insurance requests (including updated insurance information), particularly regarding coordination of benefits, or you may be billed directly.

Financial Responsibility: Patients must accept financial responsibility for any outstanding balances owed to BRMC. Patients may contact the BRMC Finance Department to discuss payment options.

Medical Information: Patients must provide accurate and complete information about their health, including past illnesses, medications, and hospitalizations.

Treatment Compliance: Patients are responsible for participation in planning and following the treatment plan established by the provider. They are responsible for their actions if they refuse treatment or do not follow the established plan.

Facilities Policies: Patients must adhere to all BRMC policies, including, but not limited to prohibition of tobacco products and vaping being used on BRMC property, no weapons, and only services animals as approved by the Americans with Disabilities Act (ADA) may be allowed.

I, (print)_____, agree to adhere to the Patient Responsibilities as described above. I understand that failure to do so may result in removal from BRMC, dismissal from receiving further services by BRMC, or may result in legal action as applicable.

_____ _____

Patient/Guardian Signature Date

For Office Use Only
Date Received: _____
Returned By: _____
BRMC Staff: _____

Blue Ridge MEDICAL CENTER
4038 Thomas Nelson Hwy, Arrington, VA 22922
Ph: 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: _____ Birth Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Adress: _____ City: _____ State: _____ Zip: _____

Email: _____

Phone #: 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	**DOB**	**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**
		Self				

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

Applicant: How often are you paid? _____ Date employment began: _____ Work Phone No. _____

Other: How often are you paid? _____ Date employment began: _____ Work 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? Name(s): _____ Insurance? _____
(Including Medicare or Medicaid)
Yes / No Name(s): _____ Insurance? _____

DECLARATIÓN: 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: _____ SS Status: _____ Eff. Dates: _____ Date/Int: _____

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Ph: 434.263.4000 ● Fax: 434.263.4160 ● Email: slide@brmedical.com

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 the 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 one 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.*

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PATIENT RIGHTS

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

- **Professional, Respectful Care, Dignity and Privacy**: Our patients will receive professional care and will be treated with dignity and respect, including privacy during treatments and examinations.
- **Safety and Freedom from Abuse**: Our patients will receive care in a safe environment, free from mental or physical abuse, neglect, or harassment and free from discrimination based on race, gender, age, religion, or sexual orientation.
- **Informed Consent and Participation**: Our patients will be fully informed about their diagnosis, prognosis, treatment plans, options, including risks, benefits and alternatives, and have the right to participate in their development. Our patients will also be informed of their financial responsibility and have the right to refuse treatment to the extent permitted by law.
- **No Surprises, Including**:
    - Protection against surprise and balance billing.
    - Right to a good faith estimate.
- **Communication**: Our patients will have the right to have a person(s) of their choice included on their emergency contacts and/or privilege to discuss list(s) to be notified of the general condition, location, and transfer of the patient to another facility. Additionally, our patients may request to have information related to their health care sent to them by sealed letter mail.
- **Freedom of Restraints**: Physical or chemical restraints are prohibited unless necessary for safety and are not to be used for convenience.
- **Medical Records Access**: Our patients have the right to review their medical records and obtain information about disclosures.
- **Confidentiality**: Medical and financial records are to be treated with strict confidentiality.
- **Concerns and Grievances**: Our patients have the right to be informed of their rights and to file complaints regarding their care without fear of reprisal.
- **Advance Directives**: Our patients have the right to create and have their Advance Directives followed, ensuring their wishes regarding medical care are respected.
- **Second Opinion**: Our patients have the right to request a consultation or second opinion from another provider at the patient's own expense.

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibilities. Your Information. Your Rights.

Our Responsibilities

1. **We are required by law to:**
   - Maintain the privacy and security of your protected health information (PHI).
   - Let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
   - Follow the duties and privacy practices described in this notice and give you a copy of it.
   - Not use or share your information other than as described here unless you tell us we can in writing. If you say we can, you may change your mind at any time by letting us know in writing.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Our Uses and Disclosures

We may use and share your information for the following reasons

1. **Treatment:**
   - We can use your health information and share it with other professionals who are treating you.
   - Example: To improve coordination of your care and treatment we may disclose Health Information, including electronic health information, to doctors, nurses, technicians, or other personnel, including people outside our office and including those health care providers who participate in Health Information Exchanges, who are involved in your medical care.
2. **Payment:**
   - **To bill for your services:** we can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
3. **Health care operations:**
   - **To run our organization**: we can use and share your health information to run our practice, improve your care, and contact you when necessary. For Example, we use health information about you to manage your treatment and services.
4. **Appointment reminders, treatment alternatives, health related benefits and services:**

- We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. For example, mailings for immunizations, vaccines, or well care.

5. **Individuals involved in your care or payment for your care:**
   - When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.
   - We may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

How we can use or share your information

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health, safety, and research. We must meet conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

1. **We can share information:**
   - To respond to lawsuits and legal actions; We can share health information about you in response to court or administrative order, or in response to a subpoena.
   - We may use a Business Associate (BA) to perform services on our behalf; All BA's are obligated to protect the privacy of your information and are not allowed to use or disclose your information other than as specified in our agreement.
2. **For public health and safety issues:**
   - Reporting suspected abuse, neglect, or domestic violence.
   - Preventing or reducing a serious threat to anyone's health or safety.
3. **We can share health information about you for certain situations such as:**
   - Preventing disease
   - Helping with product recalls
   - Reporting adverse reactions to medications
4. **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you:
   - For workers' compensation claims
   - For law enforcement purposes or with a law enforcement official
   - With health oversight agencies for activities authorized by law
   - For special government functions such as military, national security, and presidential protective services
5. **Comply with law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
6. **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
7. **To work with a medical examiner or funeral director.** We can share information with a coroner, medical examiner, or funeral director when a person dies.
8. **To do research.** We can use or share information for health research

9. **The Privacy Rule requires us to describe any state or other laws that require greater limits on disclosures.** We will never share any substance abuse treatment records without your written permission.

Your Choices

In these cases, we never share your information unless you give us written permission: marketing purposes, sale of your information, sharing of psychotherapy or behavioral health notes.

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, under the law of implied consent, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety:

- By telling family and friends about your condition
- To provide disaster relief
- To include your information in a hospital directory
- To provide mental health care

Your Rights

This section explains your rights and some of our responsibilities to help you.

1. **You have the right to get a copy of your paper or electronic medical record:**
    - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
    - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
2. **Ask us to correct your medical record:**
    - You may ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
    - We may say “no” to your request, but we’ll tell you why in writing within 60 days.
3. **Get a list of those with whom we’ve shared your information.**
    - You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
    - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

4. **Ask us to limit the information we share:**
    - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
    - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
5. **Request confidential communication:**
    - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
    - We will say “yes” if it is a reasonable request.
6. **Get a copy of this privacy notice:**
    - You can ask for a paper copy of this notice at any time. Even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.
7. **Choose someone to act for you:**
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
    - We will make sure the person has this authority and can act for you before we take any action.

Changes to this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Complaints

- You may file a complaint if you believe your privacy rights have been violated.
- You can complain if you feel we have violated your rights by contacting us in writing at: BRMC Compliance Officer at 4038 Thomas Nelson Hwy, Arrington VA 22922
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.