

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices. Our Notice of Privacy provides information about how we may use and disclose your health information. We encourage you to read it in full. **You may refuse to sign this acknowledgment.**

I acknowledge receipt of the Notice of Privacy Practices.

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Printed Name

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Signature

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Date

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## For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other

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# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION IS USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.**

## **OUR LEGAL DUTY**

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 05/01/2017, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time. Any changes in our privacy practices and the new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose your health information for treatment, payment, and other healthcare operations. The following sections describe different ways that we may use and disclose your health information.

**Treatment:** We may use or disclose your health information to other healthcare providers providing treatment to you.

**Payment:** We may use or disclose your health information to insurance and other companies to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. These healthcare operations include training programs, certification, licensing, credentialing, and quality assessment.

**Appointment Reminders:** We may use and disclose your health information to provide you with appointment reminders.

**Individuals Involved in Your Care or Payment:** We may use and disclose your health information to anyone involved with your healthcare such as a family member, friend, or other person you identify. We may also give information to someone that helps pay for your care.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose your health information to appropriate authorities to lessen or prevent a serious threat to your health or safety or the health or safety of others. Examples include abuse, neglect, and domestic violence.

**Your Authorization:** In addition to our use of your health information in connection with treatment, payment, healthcare operations, or required law, you may give us written authorization to use or disclose your health information to anyone. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**Required by Law:** We may use and disclose your health information when required to do so by law.

## **PATIENT RIGHTS**

**Right to Inspect and Copy:** You have the right to look at or get copies of your health information, with limited exceptions. To inspect or get copies of your health information, you must make a written request. If you request a copy of your information, you will be charged a cost-based fee of \$0.50 for each sheet of paper and up to \$10 search and handling fee. If you would like the copies mailed, the actual cost of postage and shipping will also be charged to you.

**Right to Disclosure of Accounting:** You have the right to receive a list of the disclosures we have made of your health information for purposes other than treatment, payment, healthcare operations, and appointment reminders. To receive this list of disclosures, you must make a written request. Your request must state a time period that may not be longer than the previous six years and not before April 14, 2003. You are entitled to one disclosure accounting list every 12 months. You will be charged a reasonable and cost-based fee for any subsequent disclosure accounting requests made within the same 12 month period.

**Right to Amendment:** You have the right to request an amendment to your health information. Your request must be written and include an explanation of when your health information should be amended. We may decline your request under certain circumstances.

**Right to Restriction:** You have the right to request additional restrictions on our use or disclosure of your health information. To request additional restrictions, you must submit a written request. We are not required to agree to your request. If we do agree with your request, we will comply with your request except in an emergency.

**Right to Alternative Communication:** You have the right to request that we communicate with you about your health information in by an alternative mean or location. Such requests must be made in writing and specify how and were you wish to me contacted. We try to accommodate all reasonable requests.

**Right to Copy of Notice:** You have the right to receive this Notice in written form. You may ask to have a paper copy of this Notice at any time.

## **QUESTIONS AND COMPLAINTS**

If you have any questions about this Notice, please contact us. If you believe your privacy rights have been violated, you may file a written complaint with us or to the U.S. Department of Health and Human Services. We respect your right to the privacy of your health information. You will not be penalized for filling a complaint to us or to the U.S. Department of Health and Human Services.

Contact Officer: Lilit  
Telephone: (703) 281-1090  
Address: 307-M Maple Avenue West, Vienna, VA 22180

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Office of Civil Rights  
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