6521 Arlington Blvd. #410
Falls Church, VA 22042

Tel: 703-261-4146-
Fax: 703-532-4356

PATIENT INFORMATION FORM

NAME: _____

HOME PHONE: (____) _____CELL PHONE: (____) _____ WORK PHONE: (____) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: M____ F____ BIRTH DATE: _____/_____/_____ SS#: _____-_____-_____

Emergency Contact – Name_____Phone #_____

EMPLOYER: _____

Primary Insurance

PRIMARY INSURANCE COMPANY: _____

CLAIM'S ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____

INSURED'S GROUP #: _____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#:_____

Secondary Insurance

SECONDARY INSURACE COMPANY: _____

CLAIM'S ADDRESS: _____
STREET OR PO BOX CITY STATE ZIP CODE

INSURED'S NAME: _____ INSURED'S ID#: _____
INSURED'S GROUP #:_____ RELATIONSHIP TO INSURED: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SS#: _____

Guarantee of Payment and Assignment of Insurance Benefits

Consent to receive medical care, assignment of Benefits Authorization, Responsibility for Payment and Acknowledgement of Receipt of Notice of Privacy Practices

I give my consent to receive medical care by professionals associated with Right Primary Care/Nova House Call MD, LLC and I understand that I am financially responsible for the services provided to me by Right Primary Care/Nova House Call MD,LLC regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Right Primary Care/Nova House Call MD, LLC for any services provided to me Right Primary Care/Nova House Call MD, LLC. I authorize and direct any holder of medical information or documentation about me to release to the centers for Medicare and Medicaid Services and its carriers and agents, as well as to Right

NOVA House Call MD, LLC

Primary Care/Nova House Call MD, LLC and its billing agents and any other payers or insurer any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Right Primary Care/Nova House Call MD,LLC, now or in the future. I agree to immediately remit to Right Primary Care/Nova House Call MD, LLC any payments that I receive from any source for the services provided to me and I assign all rights to such payment to Right Primary Care/Nova House Call MD, LLC. The undersigned hereby guarantees payment to Right Primary Care/Nova House Call MD, LLC of all charges incurred, and if account is turned over for collection, he/she agrees to pay all cost of collection including collection fee equal to 33.3% of all sum due and payable. The undersigned here agrees to pay interest at a rate of 18% per annum (annual percentage rate) on all outstanding balances.

I also acknowledge that American Care Partners @ Home, Inc manages the physicians' house call services and charges $65 (management fee) per visit. I understand that this fee is not covered by your medical insurance carriers and is an out of pocket expense.

I, _____, also acknowledge Right Primary Care/Nova House Call MD, LLC has given me a copy of the Notice of Privacy Practices. For additional information and/or questions, I am aware that I may contact the privacy officer of Right Primary Care/Nova House Call MD, LLC.

_____ _____

Patient Signature Date

_____ _____

Patient Representative's Signature Relationship to Patient

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our practice. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Use and Disclosures: Under the law, we must make disclosures to you and when required
by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.