

# PEDIATRICARE OF NORTHERN VA, P.C.

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Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information. I understand that PediatriCare of Northern Virginia, P.C. has the right to change its Notice of Privacy Practices from time to time and that I may contact PediatriCare of Northern Virginia, P.C. at any time in writing at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions if it is not feasible for PCNV to ensure compliance or believe it will negatively impact the care PCNV provides.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY ACKNOWLEDGEMENT

I acknowledge receipt of the PediatriCare of Northern Virginia Financial Policy that went into effect July 1, 2006.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_