Capital Area Physician Weight & Wellness Center
Sree L. Gogineni, MD

2235 Cedar Ln #302, Vienna, VA 22182
44121 Harry Byrd Hwy #250, Ashburn, VA 20147
2010 B Opitz Blvd, Woodbridge, VA 20191

www.capwwc.com Ph: (703)255-6010 Fax: (703)255-6011

CAPITAL AREA INTERNAL MEDICINE - dba CAPITAL AREA PHYSICIAN WEIGHT & WELLNESS CENTER (CAPWWC)

NOTICE OF PRIVACY ACT

This notice describes the way in which medical and personal information pertaining to you may be used and disclosed. It also, explains how you can access your health information. Please review it carefully and sign the attached acknowledgment receipt at the bottom of this notice and return it to the receptionist.

At CAPWWC, the staff is committed to the protection of your private health information. Within our office access to your information is limited to those employees who need access to perform their jobs.

CAPWWC may use and disclose protected health information in order to facilitate treatment, collect payments and for internal healthcare operations. Examples of these include but are not limited to referral to other healthcare providers, life insurance physicals, and home healthcare agencies. Payment examples include your health insurance provider for claims and coordination of benefits, workman's compensation, or similar programs: Collection's agencies, etc. Healthcare operations include auditing of records and internal quality control.

CAPWWC is required by law to use and/or disclose protected health information without the patients' written consent or authorization in certain circumstances. These include reporting a crime, responding to a subpoena, warrant or court order; public health officials concerned with controlling disease, disability, and injury.

CAPWWC may use or disclose protected health information to your personal representative whom you e authorized to act on your behalf in making decisions related to your health care.

CAPWWC Weight Loss Clinic will contact patients at phone numbers provided to us by the patient in order to give appointment reminders or other information regarding treatment and/or tests results.

CAPWWC Weight Loss Clinic will not use or disclose a patient's protected health information as is described in this notice without the individual's written authorization. This authorization may be revoked at

any time in writing. Exceptions are those described above as required by law.

CAPWWC Weight Loss Clinic will abide by this notice, which is currently in effect as of April 14, 2003, at the time of disclosure. We reserve the right to revise the terms of this notice and make new provisions effective for all protected health information we maintain.

CAPWWC Weight Loss Clinic will keep a posted copy of our current privacy practices in our lobby area. Copies of this notice may also be obtained at any time in our office.

Any person/patient, who believes their privacy rights have been violated, may register a complaint with our office manager at 703-255-6010, and to the Secretary of Health of Human Services.

It is our office policy that no retaliatory action will be made against any individual who submits a complaint of non-compliance with the privacy standards.

You have the legal right to inspect copies of your protected health information. This requires a written, signed, and dated request. (as allowed by State law, reasonable copy fees may apply)

If you believe your health information is inaccurate or incomplete, you may request to amend your information. In the event that we deny your request, we will inform you of our reasons for such a denial in writing.

You have the legal right to request restrictions on certain uses of your protected health information as provided by 45CFR 154.522(a). By law we are not required to comply with a requested restriction.

WEIGHT LOSS CONSENT

I authorize Dr. Sree L. Gogineni and her staff at CAPWWC to help me in my weight reduction efforts. I understand that my program may consist of a balanced diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low-calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature. I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining

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overweight or obese. Risks of this program may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

CONSUMER BILL OF RIGHTS

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 1/2 pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program. Only permanent lifestyle changes such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have the right to ask questions about the potential health risks of the program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program.

BEFORE" AND "AFTER" PHOTOS

CAPWWC may take before and after photos throughout your weight loss process, with your permission, to document and illustrate your progress.

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PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I. Procedure and Alternatives:

1. I authorize Dr. Sree L. Gogineni to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter-term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a bariatric physician, I have found the appetite suppressants helpful for periods far more than 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer-term studies, and recommendations of university-based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."

"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant used for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of the side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and maintain this weight loss. I understand my continuing to receive the appetite suppressant will be

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dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and maintain this weight loss. A balanced calorie counting program or and exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees, and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also, understand that I will have to continue watching my weight all my life if I am to be successful.

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's related questions, and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

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HOURS OF OPERATION AND CANCELLATION

We make every effort to make sure your visits are pleasant and efficient for you. Please make every effort to arrive at your appointment on time. If you are unable to make your scheduled time, just call and notify our office. (AFTER HOURS YOU CAN LEAVE A MESSAGE ON OUR PHONE)

Our patient hours are as follows:

Monday 8 AM to 4:30 PM

Tuesday 8 AM to 4:30 PM

Wednesday 8 AM to 4:30 PM

Thursday 8 AM to 4:30 PM

Friday 8 AM to 4:30 PM

If you need to miss an appointment, please call 24 hours in advance to cancel to avoid a $50.00 no-show fee. Again, you can call after hours and leave a message on our answering machine. Our phone number is 703-255-6010

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MEDICATION REFILL POLICY

Capital Area Physician Weight & Wellness Center participates with electronic prescribing directly to your mail order and local pharmacies. Our goal is to assist patients with prescription requests in an efficient and timely manner. However, due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

Capital Area Physician Weight & Wellness Center is no longer accepting medication refill requests by phone. All medication refill requests now require a follow-up appointment with one of our providers, at which time, your refill request will be submitted.

1. Prescription refills require close monitoring by your provider to ensure their safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow-up appointment. We prefer that you request any refills of your medications at the beginning of your office visit.

2. It is the patient's responsibility to notify the office to schedule a follow-up appointment, in the event you need a medication refill.

3. Patients requesting new prescriptions, or antibiotics must be seen for an appointment. They are not prescribed over the phone because it generally requires an office visit.

4. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

5. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

6. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no-shows or cancellations will result in a denial of refills.

7. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.

I understand that Capital Area Physician Weight & Wellness Center will not take medication refill requests by telephone or by automated pharmacy refill requests. All medication refill requests require a follow-up appointment, at which time your medication refill request will be submitted.

Please sign the policies acknowledgment form upon registration

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PATIENT BALANCES

All patient balances, including co-pays, deductibles, co-insurance, and self-pays are due prior to your visit. We reserve the right to cancel your appointment if your balance is not up to date.

INSURANCE CARDS AND IDENTIFICATION

All patients are required to provide their updated insurance card and identification prior to your appointment.

It is also your responsibility to bring all insurance cards and identification with you for each visit and present it to the front office to make a copy for your records.

APPOINTMENTS

In scheduling appointments, it is our intent to see you as soon as possible, given the constraints of our mutual schedules. Our staff will offer you the first available appointment and will ask you some basic questions. Our staff will make every effort to accommodate requests. We will make every effort to see you on time at your scheduled visit, however, to avoid delaying other patients; individuals arriving early for their appointments may not be taken until their scheduled time. Please be aware that emergencies do arise which might delay your scheduled appointment. You will receive a call reminding you of your appointment time. Please call us back if you need to change the time of your appointment to avoid any missed appointment charges.

BILLING INQUIRIES

Please call (703) 831-1135 for all billing questions. Our billing office staff will make every attempt to assist you at the time of your call. To facilitate their efforts, please have the necessary information available that you wish to discuss.

COMPLETION OF FORMS

We will be happy to complete attending physician's statement, insurance, and disability forms for our patients. The patient is responsible for payment of any fee prior to completion of the forms. **Please allow 10-14 business days for completion of forms.**

PRESCRIPTION REFILLS

All prescription refills must be completed at the time of your appointment. We do not refill medications by phone or automated pharmacy. Your provider will prescribe enough medication until your next follow up appointment. If you are prescribed a medication requiring more frequent office visits you must be up to date with your visits to receive a prescription refill. It will be necessary for you to schedule an office visit for your prescription to be renewed. Patients are instructed to schedule their doctor visits before running out of medicine and have all needed prescriptions before leaving the office at the time of their appointments.

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FINANCIAL POLICY
We require all of our patients to pay their portion of payment for services rendered including co-pay, co-insurance, deductible and any lab draws done in-house that are not covered by your insurance plan. Payments may be made in the form of cash, check, MasterCard and Visa. Please be aware that current federal regulations require us to collect all co-pays and bill for all services rendered.

CLINICAL PHONE CALLS
To avoid disrupting the daily patient flow, please choose the appropriate phone option and follow the instructions for a return call from the office staff. Please indicate where you may be reached during the day or whether we have permission to leave a message at the number provided. Messages are retrieved throughout the business day. Urgent requests are handled as soon as possible. All other calls requiring follow up will be returned before the end of the next business day.

TEST RESULTS
Results are generally received in our office within 7-10 days after tests have been performed. Our providers review all reports. Normal results will be posted to your patient portal or via secured email if you do not have a patient portal. For any results that require intervention, you will be contacted to set up a follow-up appointment.

REFERRALS
For those plans requiring referrals to specialty physicians, you must first receive authorization from your provider who is your designated primary care provider (PCP). To request a referral, please call the office at (703) 255-6010. If you have not been seen by your treating provider within the past six (6) months for the condition necessitating the referral, you will need to schedule an office visit prior to receiving the referral. It is patient's responsibility to inform office if a referral is required before seeing the specialist. It generally takes 2-3 business days to obtain it from the insurance.

MEDICAL RECORDS
Original records are the property of the Practice and will not be released. Per federal regulations, we require a signed Release of Medical Records form prior to processing of requests. Medical records will not be faxed. Pursuant to Virginia Code subsection B of 8.01-413, there will be charges surrounding duplication of records in the amount of $0.50 per page for up to 50 pages and $0.25 per page thereafter, plus all postage/shipping costs, and an administrative fee of $10.00. We require payment in advance. Processing will be completed within 15 days from the date we receive your signed authorization and payment. Urgent requests will be treated as such.

DELINQUENT ACCOUNTS
We reserve the right to add reasonable interest and collection charges to any account over 45 days past due. Interest of 1.5% will be added on (for each month) if the balance is not paid in full within 45 days.

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Capital Area Internal Medicine for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

YOUR INSURANCE

We will be happy to bill your insurance carrier for you. Please note that we **do not take assignment on auto-related claims** or insurance carriers that we do not participate in. If your insurance requires a referral, it is **required** that **you have your referral with you at the time of service. It is your responsibility to ensure that your referral is current**. Co- payments/co-insurance is due at the time of service. In the event your health plan determines a service to be "not covered" or it has been over sixty (45) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.**

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment

CANCELLATIONS

We require a twenty-four (24) hour notice for all cancellations; otherwise, there will be a $30 charge. Work-related cancellations are not excused cancellations, and you will incur a charge.

RETURNED CHECK

It is our office policy to charge a fee of **$35.00 for any returned checks.**

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PRIVACY PRACTICES AND CONSENT - PHI

Please review this notice carefully. It describes how your health information may be used or disclosed.

A. Our commitment to your privacy – We are committed to maintaining your privacy. We will create records of your health information and the treatment and services we provide to you. We are required by law to maintain your privacy and to notify you of our legal duties and privacy policies. We reserve the right to revise or amend this Notice of Privacy Practices - the revised or amended notice will apply to all records created in the past or future. We will post a copy of our current notice in a visible location, and you may request a copy of our current notice at any time.

B. We may use and disclose your individually identifiable health information (IIHI) in the following ways:

a) Treatment: We may use and disclose your IIHI to treat you, by having laboratory or radiology tests done to make a diagnosis or to order medication for you. People who work for our practice may use your IIHI to assist in your treatment.

b) Payment: We may use and disclose your IIHI to bill and collect payment for our service to you. We may contact your insurance company to check benefits and pre-certify a treatment. We may use and disclose your IIHI to bill you or family members for your services.

c) Health care operations: We may use and disclose your IIHI to evaluate our quality of care or our business operation.

d) Appointment Reminders: We may use and disclose your IIHI to remind you of appointments.

e) Release of information to family/friends: We may release your IIHI to family or friends who are involved in your care (with your permission).

f) Disclosures Required by Law: We will use and disclose your IIHI when we are required to do so by federal, state, or local law.

C. Use and Disclosure of your IIHI in Special Circumstances

a) Public Health: We may disclose your IIHI to public health authorities for:

i) Vital record- birth and death

ii) Reporting child abuse or domestic abuse (with the victim's permission)

iii) Preventing or controlling disease or injury (including communicable disease)

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b) Health Oversight Activities: These include investigations, inspections, audits, surveys: civil, administrative, and criminal procedures and actions: and other activities needed for compliance with government programs, civil rights law, etc.

c) Lawsuits and Similar Proceedings: We may use and disclose your IIHI as requested by a court administrative or other lawful order. We will make an effort to inform you of the request.

d) Law Enforcement: We may release your IIHI if asked by a law enforcement official

i) To investigate a crime

ii) In response to a warrant, summons, court order, subpoena, etc.

e) Serious Threats to Health or Safety: of an individual or the public.

f) Military: We may disclose your IIHI if required by the appropriate authorities.

g) National Security: We may disclose your IIHI to federal officials authorized by law.

h) Workers Compensations: We may release your IIHI for these programs.

I hereby give my consent for Capital Area Internal Medicine to use and disclose my IIHI as outlined above to carry out treatment, payment, and health care operations (HCO).

With this consent, Capital Area Internal Medicine, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the proactive in carrying out HCO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, Capital Area Internal Medicine may mail to my home or other alternative location any items that assist the practice in carrying out HCO, such as appointment reminders and patient statements. I have the right to request that Capital Area Internal Medicine restrict how it uses or discloses to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Capital Area Internal Medicine to use and disclose my IIHI to carry out HCO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Capital Area Internal Medicine may decline to provide treatment to me.