

Virginia Endocrinology & Osteoporosis Center, Inc

Akta Mukherjee, MD • Ben Phillips, MD • Cynthia Ryan, MD • Kelsey Salley, MD • Jeffrey Sicat, MD

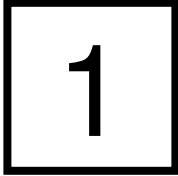
2384 Colony Crossing Place

Midlothian, Virginia 23112

(804) 423-3636(tel)

(804) 423-3637(fax)

www.VirginiaEndo.com



FORM #1: NEW PATIENT DEMOGRAPHIC INFORMATION

Patient Information	
Title (Mr., Mrs., Miss...)	
Last Name	
First Name	
Middle Name	
Address Line 1	
Address Line 2	
City	
State	
Zip Code	
Home Phone	
Work Phone	
Cell Phone	
Fax number	
Okay to leave a medical message at your home?	
Okay to leave a medical message on your cell?	
E-mail address	
Okay to email you a reminder for your appt?	
Primary Care Doctor	
Primary Care Doctor phone	
Referring Doctor	
Birthday (mm/dd/yyyy)	
Gender	
Social Security #	
Employer Name	
Emergency Contact	
Last Name	
First Name	
Home Phone	
Work Phone	
Relationship to Patient	

Insurance Information	
Insurance Company	
Name of Insured Person	
Insured Person's birth date	
Other Insurance Company	
Medicaid ID #	
Pharmacy	
Pharmacy Name	
Address	
City	
Telephone Number	
Fax Number	

NEW PATIENT CHECKLIST

- Referral.** We require that you obtain a referral from your primary care physician. Please call their office and request that they fax the referral to us at (804) 423-3637
- Medical Records.** Please call your primary care physician's office and request them to fax a copy of your medical records to us.
- Insurance Card.** Please bring your insurance card
- Medications.** Please bring all of your medication bottles to your visit.
- Patients with Diabetes.** If you have diabetes, please bring your blood sugar meter and blood sugar record. For the week prior to your visit, we request that you check your sugars 4 times a day (before each meal and bedtime) and bring these numbers written down to your appointment.
- Cancellation and Missed Appointments.** If you are not able to keep your appointment, we request that you call at least 72 hrs in advance, so that we may be able to provide more timely care to other patients who could be scheduled into your reserved time slot.
- At least 24 hours notice is required for the cancellation of all appointments. A \$25 charge will be added to your account if 24 hours notice is not received prior to a missed appointment.**

- **UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637.**
- **IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!**

ALLERGIES: Allergies or Adverse Reactions to medications or other substances – please list drug names with allergic reactions below

SURGERIES

Year	Surgery	Hospital

HOSPITALIZATIONS

Year	Reason	Hospital

FAMILY HEALTH HISTORY (PLEASE FILL IN FOR THOSE MEMBERS WITH WHOM YOU ARE FAMILIAR)

Are you Adopted **YES** **NO** IF YOU ARE ADOPTED, YOU DO NOT NEED TO COMPLETE THE FOLLOWING

	LIVING/DECEASED	AGE	SIGNIFICANT HEALTH CONDITIONS
Mother			
Father			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			

<p>Please list any other significant medical conditions that run in any other family members here</p>	

SOCIAL HISTORY			
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Separated
	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Living	<input type="checkbox"/> Live alone	<input type="checkbox"/> Live with significant other	
	<input type="checkbox"/> Live with spouse	<input type="checkbox"/> Live with other	
Employment	<input type="checkbox"/> Occupation / Employer →		
	<input type="checkbox"/> Homemaker		
	<input type="checkbox"/> Student (where, major, year) →		
Tobacco	<input type="checkbox"/> NO - I do not smoke and have never smoked		
	<input type="checkbox"/> YES - I previously smoked but no longer smoke	Quit date?	
		Previous # of packs per day?	
		Previous total # of yrs smoking?	
	<input type="checkbox"/> YES – I am currently smoking	Number of packs per day?	
Number of years smoking?			
Alcohol	<input type="checkbox"/> NO - I do not drink any alcohol		
	<input type="checkbox"/> YES – I previously drank alcohol but no longer drink alcohol	Quit Date?	
		Type of alcohol?	
		Number of drinks per week?	
		Years drinking?	
	<input type="checkbox"/> YES – I drink alcohol	Type of alcohol?	
		Number of drinks per week?	
		Years drinking?	
Drugs	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	What type of street drugs have you used in the past or are currently using		
Sexual History	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you currently trying to become pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying to become pregnant, list contraceptive or barrier method using:		
	When was your last menstrual period? How many periods do you have per year?		
Military History	Have you ever been in the military service?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If so, which branch?	<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserves <input type="checkbox"/> Other	

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Name:

Date of Birth:

	DO YOU HAVE THE FOLLOWING SYMPTOMS?	IF YES, PLEASE EXPLAIN:	
GEN	Weight Gain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Weight Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Fatigue	<input type="checkbox"/> No	<input type="checkbox"/> Yes
EYE	Loss of Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Double Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Bulging Eyes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
ENT	Hearing Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Hoarse Voice	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Loss of smelling	<input type="checkbox"/> No	<input type="checkbox"/> Yes
CARD	Chest pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Palpitations	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Leg Swelling	<input type="checkbox"/> No	<input type="checkbox"/> Yes
PULM	Shortness of breath	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Coughing	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Wheezing	<input type="checkbox"/> No	<input type="checkbox"/> Yes
ABDO	Abdominal Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Nausea / Vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Constipation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Diarrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes
UROL	Frequent Urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Difficulty Urinating	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Urinating at night	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Kidney Stones	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Problems with Erections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
GYN	Irregular menstrual cycles	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Post-menopausal	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Hot flashes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
MSK	Joint Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Back Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Fractures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Muscle Cramping	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Loss of height	<input type="checkbox"/> No	<input type="checkbox"/> Yes
NEUR	Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Tremors	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Numbness in hands / feet	<input type="checkbox"/> No	<input type="checkbox"/> Yes
HEME	Easy bruising	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Frequent Nosebleeds	<input type="checkbox"/> No	<input type="checkbox"/> Yes
PSYCH	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Trouble Sleeping	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Eating Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes
DERM	Acne	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Dry Skin	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Extra facial hair growth	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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DIABETES FORM:

IF YOU HAVE DIABETES, PLEASE COMPLETE THIS FORM AS WELL

Name (Last, First Middle)						Date of Birth:
What year were you diagnosed with diabetes						
How old were you when you were diagnosed with diabetes						
Have you had any diabetes complications, like	Eye problems (diabetic retinopathy)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
	Nerve problems (diabetic neuropathy)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
	Kidney problems (diabetic nephropathy)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
	Heart problems, stroke, or blood vessel blockages?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
What pills (and doses) do you take for diabetes						
If you are insulin, what year did you start taking insulin						
Please list the insulin type, dose, and times of the day that you take it						
How many times a day do you check your sugars						
During the last month, what have been your sugars been: (generally speaking)						
Fasting / pre-breakfast sugars	Lowest		Highest		Usual	
Pre-lunch sugars	Lowest		Highest		Usual	
Pre-dinner sugars	Lowest		Highest		Usual	
Bedtime sugars	Lowest		Highest		Usual	
PNEUMONIA VACCINATION:	What year did you get your last pneumonia vaccine?					
	<p>If you have <u>not</u> had a pneumonia vaccination: The Centers for Disease Control (CDC) recommends that all people with diabetes receive a pneumonia vaccination to reduce your chance of getting a bacterial pneumonia infection. It protects against 23 types of pneumococcal bacteria. It is recommended once before the age of 65 and once after the age of 65 but not within 5 years of a previous pneumonia vaccination.</p> <p>Some people develop mild side effects like redness or pain at the site of injection, and some people develop fevers and muscle aches. Severe allergic reactions have been reported rarely.</p>					Do you want a pneumonia vaccination during your initial clinic visit? <input type="checkbox"/> No <input type="checkbox"/> Yes
FLU SHOT:	Have you had a flu shot during this flu season (between October and February)? If so, in what month and year did you have it?					
	<p>If you have <u>not</u> had a flu shot: A yearly flu shot is recommended to people with diabetes. Side effects include redness or pain at the site of injection and some people develop fevers and muscle aches. Severe allergic reactions have been reported rarely. DO NOT TAKE THE FLU SHOT IF YOU ARE ALLERGIC TO EGGS.</p>					Do you want a flu shot during your initial clinic visit? <input type="checkbox"/> No <input type="checkbox"/> Yes
ASPIRIN: The American Diabetes Association (ADA) recommends that most <u>people over the age of 40 with diabetes take an aspirin daily</u> to prevent cardiovascular disease. Do you take an aspirin every day?					<input type="checkbox"/> No	<input type="checkbox"/> Yes
CHOLESTEROL: The American Diabetes Association recommends that <u>people over the age of 40 with diabetes take a cholesterol medicine</u> , no matter what your cholesterol. They are known to prevent heart disease. Are you taking a cholesterol medicine?					<input type="checkbox"/> No	<input type="checkbox"/> Yes
EYE EXAM: It is recommended that all people with diabetes have a yearly eye exam. When was your last eye exam? (month/year)						

- Please bring your **BLOOD GLUCOSE METER** and your **GLUCOSE LOG** to your visit
- Please bring all of your medications with you to your visit
- Please fax these forms to (804) 423-3637 prior to your visit, or come 30 minutes prior to your appt



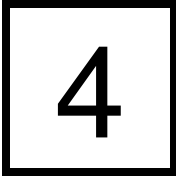
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FORM #3: AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO THE VIRGINIA ENDOCRINOLOGY & OSTEOPOROSIS CENTER

Patient's Name:		Date of Birth:	
Previous Name:		Social Security #:	
I request and authorize (Primary care doctor or referring physician)			
To release healthcare information of the patient named above to:			
Virginia Endocrinology & Osteoporosis Center 2384 Colony Crossing Place Midlothian, Virginia 23112 (804) 423-3636 phone (804) 423-3637 fax			
This request and authorization applies to:			
<input type="checkbox"/>	All healthcare information		
<input type="checkbox"/>	Healthcare information relating to the following treatment, condition, or dates:		
SIGN IN THE SPACE BELOW			
Patient Signature:		Date Signed:	
THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER IT IS SIGNED			

- UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637.
- IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!



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FORM #4: AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FROM THE VIRGINIA ENDOCRINOLOGY & OSTEOPOROSIS CENTER TO FAMILY MEMBERS

Patient's Name:	
Date of Birth	
Home Phone #:	
Fax #:	

I authorize the Virginia Endocrinology & Osteoporosis Center to release medical and billing information, either in person, over the phone, or in writing, to the following people:

Name:		Name:	
Home Phone #:		Home Phone #:	
Name:		Name:	
Home Phone #:		Home Phone #:	

I understand that the person(s) that I have named above to receive private health information may be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it

Please specify below how we may contact you with private health information (check all that apply)

<input type="checkbox"/> Call my home phone but do not leave a message	
<input type="checkbox"/> Call my home phone and leave a message on the machine	
<input type="checkbox"/> You can leave a message at home with the following people:	
<input type="checkbox"/> Call my cell phone and leave a message	
<input type="checkbox"/> Call my work phone but do not leave a message	
<input type="checkbox"/> Call my work phone and leave a message on the machine	
<input type="checkbox"/> You can leave a message at work with the following people:	
<input type="checkbox"/> Send my health information in the mail	

SIGN IN THE SPACE BELOW

Patient Signature:		Date Signed:	
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THIS AUTHORIZATION EXPIRES 5 YEARS AFTER IT IS SIGNED

- UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637.
- IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!



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FORM #5: CANCELLATION AND MISSED APPOINTMENT POLICY FINANCIAL POLICY INSURANCE AUTHORIZATION

CANCELLATION AND MISSED APPOINTMENT POLICY

Our practice philosophy is to provide comprehensive patient care by reserving dedicated blocks of time for each patient. Therefore, if you are not able to keep your appointment, we request that you **call at least 72 hours in advance** to let us know. This will allow us to provide more timely care to other patients who could be scheduled into your reserved time slot.

At least 24 hours notice is required for the cancellation of all appointments. A \$25 charge will be added to your account if 24 hours notice is not received prior to a missed appointment. Insurance will not pay for this charge.

We reserve the right to terminate the physician-patient relationship in the case of any missed initial or follow-up appointment(s). Our policy is that if you miss your initial appointment without calling, we will not reschedule you.

FINANCIAL POLICY

As a courtesy to its patients, Virginia Endocrinology & Osteoporosis Center will file insurance claims upon the receipt of a current insurance card. If coverage is denied, you will be billed and payment in full is due upon the receipt of the bill. You will also be responsible for all co-payments (co-pays) at the time of the visit, as well as deductibles and balances due following insurance payments.

It is your responsibility, with the help of Virginia Endocrinology & Osteoporosis Center, to ensure that all referrals and authorizations are obtained prior to receiving medical care. If the referral/authorization is not obtained and your claim is denied, you will be responsible for the balance.

In the event that your account, following insurance payments and the normal billing cycle of Virginia Endocrinology & Osteoporosis Center, is not paid in full within thirty days from the date of service, you will be responsible for any additional special handling fees should your account fall into past due status.

Past due amounts that are **greater than 90 days overdue are subject to being turned over to a collection agency.** You are strongly encouraged to pay all past due amounts promptly or set up a payment plan with us.

There is a **\$25.00 charge for returned checks.** If two (2) checks are returned, you will no longer be able to write checks in our office. Payments must then be made either by cash, credit card, money order, or certified check.

INSURANCE AUTHORIZATION

You authorize any holder of medical or other information about you to be released to the insurance payor or other secondary insurance, as listed in your file, any information needed for the insurance claim(s). You permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to you or to Virginia Endocrinology & Osteoporosis Center, who accepts assignment.

SIGN IN THE SPACE BELOW

Patient Name (printed):		
Patient Signature:		Date Signed:



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FORM #6: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (NOPP) provides information about how we may use and disclose personal health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have reviewed a copy of the Virginia Endocrinology & Osteoporosis Center's Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Virginia Endocrinology & Osteoporosis Center if I do not understand any information contained in the Notice of Privacy Practices.

Patient's Printed Name	
Patient's Signature	
(if applicable) Patient's Personal Representative & Relationship	
(if applicable) Patient's Personal Representative's Signature	
Date	

The following section is for use by Virginia Endocrinology & Osteoporosis Center personnel if unable to obtain a written acknowledgement of receipt of the NOPP from the patient.

I have made a good faith effort to obtain a written acknowledgement of receipt of the Virginia Endocrinology & Osteoporosis Center's Notice of Privacy Practices from the above named patient, but was unable to for the following reason(s):

- Language Barrier
- Patient Cannot Read
- Patient Objects
- Read Later and Return
- Unable to Sign
- Other:

Employee Name and Date: _____

<ul style="list-style-type: none"> • UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637. • IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!

Virginia Endocrinology & Osteoporosis Center
Notice of Privacy Practices (page 1 of 2) (Keep for your records)

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. If you have any questions, please contact our privacy office at the address or phone number at the bottom of this notice.

Who will follow this notice?

Virginia Endocrinology & Osteoporosis Center (VEOC) provides health care to our patients in partnership with other health care professionals. The information privacy practices in this notice will be followed by:

- Any healthcare professionals who treat you at any of our locations.
- All employees, medical staff, trainees, students, or volunteers of the entities listed above.

Our pledge to you:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by any of the separate facilities and providers described above. We are required by law to:

- Keep medical information about you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you:

- We may use and disclose medical information about you without your prior authorization for treatment (such as sending medical information about you to another healthcare provider or specialist as part of a referral) (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our healthcare operations (such as comparing patient data to improve treatment methods

or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes without your authorization). If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures other than emergencies).

- Other examples of such uses and disclosures include contacting you for appointment reminders and telling you about or recommending possible treatment options, alternatives, health-related benefits or services that may be of interest to you.

- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

- Under certain circumstances, we may use and disclose health information about you for research purposes, subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the health information they review does not leave our facility, and so long as they agree to specific privacy protections.

- If admitted as an inpatient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and may release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to clergy members, even if they do not ask for you by name.

- We may disclose medical information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction. We may also disclose information to

Virginia Endocrinology & Osteoporosis Center
Notice of Privacy Practices (page 2 of 2) (Keep for your records)

disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information:

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and or Amend Your Records:

- In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

- If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:

- You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

- To request this list of disclosures, indicate the relevant period, which must be after February 1, 2005. You must submit your request in writing to the Privacy Office listed below.

Right to Request Restrictions:

You may request, in writing, that we not use or disclose medical information about you for treatment, payment

or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request. All written requests or appeals should be submitted to the Privacy Office listed below.

Requests for Confidential Communications:

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:

You may receive a paper copy of this Notice from us upon request.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas. You can receive a copy of the current notice at any time. The effective date is listed at the end. You will be asked to acknowledge in writing your receipt of this notice.

Complaints:

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Office listed below.

- If you are not satisfied with our response, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Office – Office Manager
Virginia Endocrinology & Osteoporosis Center
2384 Colony Crossing Place
Midlothian, Virginia 23112
(804) 423-3636

Virginia Endocrinology & Osteoporosis Center, Inc

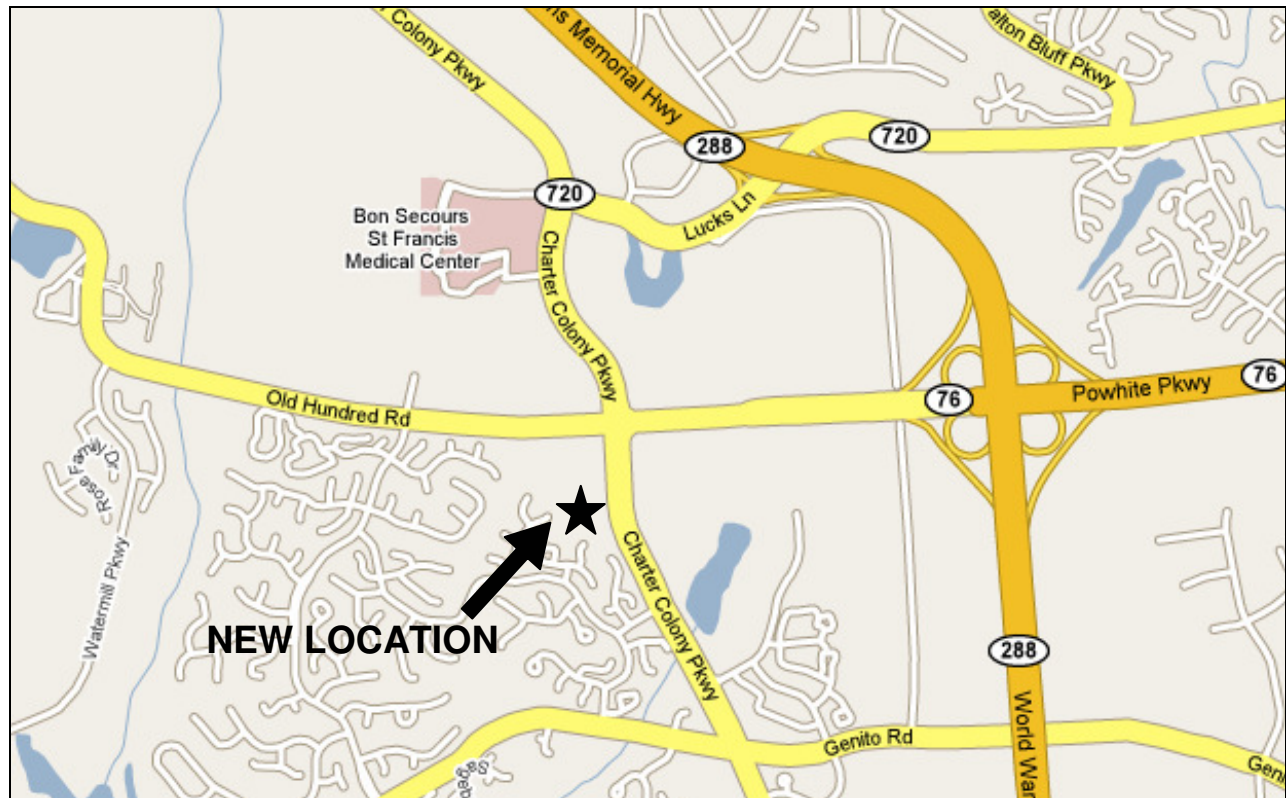
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OUR LOCATION AND DRIVING DIRECTIONS:

**2384 Colony Crossing Place
Midlothian, VA 23112**

This location is located 1 block (1/3 mile) from St. Francis Medical Center literally at the intersection of the Powhite Parkway (76) and Charter Colony Parkway near the entrances to the Brandermill neighborhoods. We are in the Colony Crossing office park located directly behind Dolce Vita (Italian Restaurant), Padow's sandwich shop, Colony Coffee, and the daycare. The entrance to the office park is located on Charter Colony Parkway.

Due to the newness of the office complex, please note that directions through Mapquest, Yahoo, Google, and other internet driving directions may NOT be available or correct as they might direct you to the wrong location. The location on the map is below:



Specific Written Directions are printed on the following pages:

From the Southside of Richmond (via Midlothian Turnpike):

Take Midlothian turnpike West and pass Chesterfield Towne Center,
Travel west on Midlothian Turnpike for about 1.6 miles,
Turn left on N. Woolridge Road and travel for about 1.5 miles,
Turn left on Charter Colony Parkway and travel about 2.5 miles,
Pass St. Francis Medical Center on the right, and travel another 1/4 mile,
You will come to a stoplight which is the intersection with the Powhite Parkway,
Our office is located on the far right hand corner in "Colony Crossing Place."
Pass through the stoplight and immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384.

From the Southside of Richmond (via the Powhite Parkway):

Take the Powhite Parkway (76) South until the Powhite Parkway ends at Old Hundred Road,
The Powhite Parkway ends at a stoplight and our office complex is in the far left corner,
We are located in the complex called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384.

From Downtown Richmond and the Fan Area:

Take 195 South and merge onto the Powhite Parkway (76),
On the Powhite Parkway travel about 11 miles until the Powhite Parkway ends at Old Hundred Road / Charter Colony Parkway,
The Powhite Parkway ends at a stoplight and our office complex is on the far left corner,
We are located in the complex called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384

From the West End of Richmond:

Take 64 West to exit 175 (route 288 South),
Travel on route 288 South for about 15 miles,
Pass the exit for Lucks lane and immediately get into the right hand lane,
Bear immediately to the right and follow signs for the 76 South Toward Old Hundred Road,
Follow the Powhite Parkway South (76 South) for 1/3 mile,
The Powhite Parkway ends at a stoplight (at Old Hundred Road and Charter Colony Pkwy),
We are located in the complex on the far left corner called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384

From east of Richmond (Eastern Henrico County, Williamsburg, Newport News)

Take 64 West/ 95 North and continue past downtown Richmond,
64 West and 95 North will eventually separate,
Stay in the right lane and stay on 64 West, then immediately get in the left lane,
Take 195 South and merge onto the Powhite Parkway,
On the Powhite Parkway travel about 11 miles until the Powhite Parkway ends at Old Hundred Road / Charter Colony Parkway,
The Powhite Parkway ends at a stoplight (Old Hundred Road and Charter Colony Pkwy),
We are located in the complex at the far left corner called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384

From Petersburg and areas south of Richmond:

From the Petersburg area, take 95 North,
Take exit 62, Route 288 North
Travel on Route 288 North for about 16 miles
Follow signs and directions to the 76 South and Old Hundred Road),
The Powhite Parkway (76 South) ends at a stoplight (Old Hundred Road and Charter Colony Pkwy),
We are located in the complex at the far left corner called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384

From Hanover and areas north of Richmond (via the Powhite Parkway):

Take 95 South to exit 79 (64 West/195 South/ Powhite Parkway)
Take 195 South and merge onto the Powhite Parkway,
Travel on the Powhite Parkway about 11 miles until it ends at Old Hundred Road,
The Powhite Parkway ends at a stoplight and our office complex is in the far left corner,
We are located in the complex called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384

From Hanover and areas north of Richmond (via the West End by Route 288):

Take 95 South to exit 84B and take 295 West towards Charlottesville,
Travel on 295 West for about 6 miles until it merges onto 64 West,
Take 64 West to exit 175 (route 288 South),
Travel on route 288 South for about 15 miles,
Pass the exit for Lucks lane and immediately get into the right hand lane,
Bear to the right and follow signs for the Powhite Parkway South (76 South),
Follow the Powhite Parkway South (76 South) for 1/3 mile until it ends at a stoplight,
We are located in the complex on the far left corner called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384

From Blackstone, Amelia, Burkeville, and areas southwest (via Hull Street / Rt 360)

Take 360 (Hull Street) East towards Richmond,
Once in Midlothian, pass the the Swift Creek Reservoir, then pass Old Hundred Road,
Turn right onto route 288 North (jug handle),
Follow the signs for the 76 South towards Old Hundred Road,
Remain on the Powhite Parkway South (76 South) until it ends at the first stoplight,
We are located in the complex on the far left corner called "Colony Crossing Place."
Turn left at the stop light onto Charter Colony Parkway,
Immediately turn right at the next light into the first driveway,
Our office is located behind the stores for Padow's and the Dolce Vita restaurant
Once in the complex, our office is in the third building on the left in #2384