



PATIENT INFORMATION

Personal Information*

Prefix: Mr./Mrs./Other: Patient Name*: Suffix: Jr./Sr./Other:

Previous Name: Preferred Name: Email:

Mailing Address*:

Home #: Cell #: Work #: Ext: City State Zip

Method of Contact for Appointment Reminders: Text Message Home Phone Cell Phone

Primary Care Provider (PCP): Address: Phone #:

Referring Provider: Address: Phone #:

Date of Birth*: Birth Sex*: Marital Status*: Single Married Widowed Separated Divorced

Social Security #: Employer Name: Occupation:

Employment Status: Full Time Part Time Not Employed Self Employed Retired Active Military Unknown

Student Status: Full Time Part Time N/A

Additional Information*

Race*: Caucasian/White Asian Black/African American Hawaiian/Pacific Islander Other:

Ethnicity*: Hispanic/Latino Non-Hispanic or Latino

Gender Identity: Male Female Female-To-Male (FTM)/Transgender Male/Trans Man Male-To-Female (MTF)/Transgender Female/Trans Woman Genderqueer, neither exclusively male nor female Choose not to disclose Other, please specify:

Language*: English Spanish Other:

Sexual Orientation: Lesbian, gay/homosexual Straight/heterosexual Bisexual Don't know Choose not to disclose Something else:

Pharmacy Name*: Address: Phone #:

Emergency Contact*

Name: Relationship:

Address: Street Address Apt # City State Zip

Home #: Work #: Cell #:

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name: Date of Birth: Birth Sex: Social Security #

Address: Street Address Apt # City State Zip

Home #: Cell #: Work #: Ext:

Primary Insurance Information*

Insurance Name: Member ID #: Relationship to Insured:

Employer: Group #: Effective Date: mmm/dd/yyyy

Insured's Information* - (if not self)

Name: Date of Birth: Birth Sex: Social Security #

Relationship to Insured: Marital Status*: Single Married Widowed Separated Divorced

Address: Street Address Apt # City State Zip

Home #: Work #: Cell #:

Secondary Insurance Information

Insurance Name: Member ID #: Relationship to Insured:

Group #: Effective Date:

Secondary Insured's Information - (if not self)

Name: Date of Birth: Birth Sex: Social Security #

Relationship to Insured: Marital Status*: Single Married Widowed Separated Divorced

Address: Street Address Apt # City State Zip

Home #: Work #: Cell #:

CONSENT INFORMATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG, PC or any of its affiliates. I also authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration. _____ (Please initial)

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If any LMG health professional, worker or employee should be directly exposed to your blood or your body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. _____ (Please initial)

If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test. _____ (Please initial)

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents

_____ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out

_____ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan. Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on all patients prescribed controlled substances.
- In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RXHub and Virginia Prescription Monitoring Program. _____ (Please initial)

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

Date

Relationship (if any)

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

Patient's Name

I have received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

Signature

Date: _____

Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) <u>Other:</u>

LOUDOUN MEDICAL GROUP

NOTICE OF PRIVACY LOUDOUN MEDICAL GROUP

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.

Effective Date: **2/16/2026**

If you have any questions about this notice, please contact the Loudoun Medical Group Privacy Officer at (703) 737-6010.

WHO WILL FOLLOW THIS NOTICE

This notice describes the Loudoun Medical Groups of:

- Loudoun Medical Group.
- Any health care professional authorized to enter information into your medical record maintained by Loudoun Medical Group.
- Any persons or companies with whom Loudoun Medical Group contracts for services to help operate our Loudoun Medical Group and who have access to your medical information.
- All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or health care operations purposes and other purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from Loudoun Medical Group. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care and billing for that care that are generated or maintained by Loudoun Medical Group, whether made by Loudoun Medical Group personnel or other health care providers. Other health care providers may have different policies or notices about confidentiality and disclosure that apply to your medical information that is created in their offices or at locations other than Loudoun Medical Group.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy Loudoun Medical Groups at Loudoun Medical Group, and your legal rights, with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, volunteers, or other personnel who are involved in taking care of you at Loudoun Medical Group. For example, a doctor treating you for a broken hip may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about you to people outside Loudoun Medical Group who may be involved in your medical care after you have been treated by Loudoun Medical Group, such as friends, family members, or employees or medical staff members of any hospital or skilled nursing facility to which you are transferred or subsequently admitted.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from Loudoun Medical Group may be billed by Loudoun Medical Group and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received from Loudoun Medical Group so your health plan will pay us or reimburse you for the treatment. We also may disclose information about you to another health care provider, such as a hospital or skilled nursing facility to which you are admitted, for their payment activities concerning you.

- **For Health Care Operations.** We and our business associates may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Loudoun Medical Group and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Loudoun Medical Group should offer, and what services are not needed. We may also disclose information to doctors, nurses, technicians, and other personnel affiliated with Loudoun Medical Group for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identities of specific patients. We also may disclose information about you to another health care provider for its health care operations purposes if you also have received care from that provider.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend different ways to treat you.
- **Fundraising Activities.** We may use medical information about you to contact you in an effort to raise money for Loudoun Medical Group and its operations. Specifically, we may use information about you to target our fundraising efforts. For example, if we are raising money for women's health services, we may focus our fundraising efforts on individuals who have received women's health services from us in the past. We may also disclose medical information to a business partner or a foundation related to Loudoun Medical Group so that the business partner or the foundation may contact you in raising money for Loudoun Medical Group. We would release limited information about you, such as your name, address and phone number, age and date of birth, gender, your physician, and the dates you received treatment or services at Loudoun Medical Group.

If you do not want Loudoun Medical Group to contact you for fundraising efforts, you must notify Loudoun Medical Group's Privacy Officer in writing. If you have not already done so, we must ask you each time we contact you for fundraising efforts if you wish to opt out of all future fundraising communications. If you do opt out of future fundraising communications, we will no longer disclose your information for fundraising purposes. However, in the future you may let us know in writing that you would like to receive these fundraising communications. Your decision whether or not to receive targeted fundraising materials from us will have no impact on your access to health care services or the treatment we provide to you.

Even if you have opted-out, we may send you non-targeted fundraising materials that are sent out to the general community and are not based on information from your treatment.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. Medical information about you that has had identifying information removed may be used for research without your consent. We also may disclose medical information about you to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs), so long as the medical information they review does not leave Loudoun Medical Group. If the researcher will have information about your mental health treatment that reveals who you are, we will seek your consent before disclosing that information to the researcher. Unless we notify you in advance and you give us written permission, we will not receive any money or other thing of value in connection for using or disclosing your medical information for research purposes except for money to cover the costs of preparing and sending the medical information to the researcher.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.
- **As Required or Permitted By Law.** We may disclose medical information about you when required or permitted to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when it appears necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

SPECIAL SITUATIONS

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Active Duty Military Personnel and Veterans.** If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.
- **Workers' Compensation.** In accordance with state law, we may release without your consent medical information about your treatment for a work-related injury or illness or for which you claim workers' compensation to your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose without your consent medical information about you for public health activities. These activities generally include but are not limited to the following:
 - To report, prevent or control disease, injury, or disability;
 - To report births and deaths;
 - To report reactions to medications or problems with products;
 - To notify people of recalls of products they may be using;
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
 - To report suspected abuse or neglect as required by law.
- **Health Oversight Activities.** We may disclose without your consent medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a court or administrative order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a civil dispute.
- **Law Enforcement.** We may release without your consent medical information to a law enforcement official:
 - In response to a court order, warrant, summons, grand jury demand, or similar process;
 - To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings;
 - In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person;
 - To report a death or injury we believe may be the result of criminal conduct; and
 - To report suspected criminal conduct committed at Loudoun Medical Group facilities.
- **Coroners and Medical Examiners.** We may release without your consent medical information to a coroner or medical examiner. This may be done, for example, to identify a deceased person or determine the cause of death. We also may release medical information about deceased patients of Loudoun Medical Group to funeral directors to carry out their duties.
- **National Security and Intelligence Activities.** We may release without your consent medical information about you as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
- **Psychotherapy Notes.** Regardless of the other parts of this Notice, psychotherapy notes will not be disclosed outside the Loudoun Medical Group except as authorized by you in writing or pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within Loudoun Medical Group, except for training purposes or to defend a legal action brought against Loudoun Medical Group, unless you have properly authorized such disclosure in writing.
- **Substance Use Disorder Treatment Information.** If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") based upon a general consent you provide to the Part 2 Program to use and disclose your Part 2 Program record for purposes of treatment, payment, or health care operations, we may use and disclose your Part 2 Program record for treatment, payment, and health care operations purposes as described in this notice. If we are a Part 2 Program and create a Part 2 Program record for you, or if we receive or maintain your Part 2 Program record based upon a specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

- **Marketing of Health-Related Products and Services.** "Marketing" means a communication for which we receive any sort of payment from a third party that encourages you to use a service or buy a product. Before we may use or disclose your medical information to market a health-related product or service to you, we must obtain your written authorization to do so. The authorization form will let you know that we have been paid to make the communication to you. Marketing does not include: prescription refill reminders or other information that describes a drug you currently are being prescribed, so long as any payment we receive for that communication is to cover the cost of making the communication; face-to-face

communications; or gifts of nominal value, such as pens or key chains stamped with our name or the name of a health care product manufacturer. Communications made about your treatment, such as when your physician refers you to another health care provider, generally are not marketing.

- **Sale of Medical Information.** We cannot sell your medical information without first receiving your authorization in writing. Any authorization form you sign agreeing to the sale of your medical information must state that we will receive payment of some kind disclosing your information. However, because a “sale” has a specific definition under the law, it does not include all situations in which payment of some kind is received for the disclosure. For example, a disclosure for which we charge a fee to cover the cost to prepare and transmit the information does not qualify as a “sale” of your information.
- **Inmates.** If you are an inmate of a correctional institution or in the custody of law enforcement, we may release medical information about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to Loudoun Medical Group that such medical information is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the North Carolina Department of Corrections (“DOC”) and the DOC requests your medical records, we are required to provide the DOC with access to your records.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and receive a copy of your medical record unless your attending physician determines that information in that record, if disclosed to you, would be harmful to your mental or physical health. If we deny your request to inspect and receive a copy of your medical information on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by Loudoun Medical Group will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides.

If we have all or any portion of your medical information in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

Your medical information is contained in records that are the property of Loudoun Medical Group. To inspect or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Loudoun Medical Group’s Privacy Officer. If you request a copy of the information, **we may charge a fee** for the costs of copying, mailing, or other supplies associated with your request, and we may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation.

- **Right to Amend.** If you feel that medical information we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Loudoun Medical Group.

To request an amendment, make your request in writing to Loudoun Medical Group’s Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Loudoun Medical Group;
- Is not part of the information that you would be permitted to inspect and copy; or
- Has been determined to be accurate and complete.

If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your medical record.

- **Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we have made of medical information about you during the past six years.

To request this list or accounting of disclosures, submit your request in writing to Loudoun Medical Group’s Privacy Officer and state whether you want the list on paper or electronically. Your request must state a time period that may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.

- **Right to Request Restrictions.** Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could revoke any and all authorizations you previously gave us relating to disclosure of your medical information.

We are not required to agree to your request, with the exception of restrictions on disclosures to your health plan, as described below. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, make your request in writing to Loudoun Medical Group's Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You may request that we not disclose your medical information to your health insurance plan for some or all of the services you receive during a visit to any Loudoun Medical Group location. If you pay the charges for those services you do not want disclosed **in full at the time of such service**, we are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to the Privacy Officer and specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice or any revised notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, request a copy from Loudoun Medical Group's Privacy Officer in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Loudoun Medical Group's office. The notice will contain the effective date on the first page, in the top right-hand corner. If the notice changes, a copy will be available to you upon request.

INVESTIGATIONS OF BREACHES OF PRIVACY

We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Loudoun Medical Group or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Loudoun Medical Group, contact Clara Nussbaum, Loudoun Medical Group's Privacy Officer by mail at 224-D Cornwall Street, NW, Suite 403, Leesburg, VA 20176. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice may be made only with your written authorization or as required by law. If you authorize us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. Your revocation will be effective as of the end of the day on which you provide it in writing to Loudoun Medical Group's Privacy Officer. If you revoke your permission, we will no longer use or disclose medical information about you for the purposes that you previously had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



205 E. Hirst Road ■ Suite 200 ■ Purcellville, VA 20132 ■ Ph: 540-338-6101 ■ Fax: 540-338-7803

HEALTH HISTORY FORM

Name: _____ **Date of Birth:** _____

What is the reason for your visit today?

PAST MEDICAL HISTORY (Conditions that you currently have and are being treated for, conditions that you have been treated for in the past. Examples: High blood pressure, diabetes, anxiety, depression, sleep apnea, cancer, etc.)

PAST SURGICAL HISTORY (Examples: Tonsillectomy, sinus surgery, appendectomy, heart stent, etc.)

CURRENT MEDICATIONS (Attach a list of medications if preferred. If none, please write none. If you need more room, please use the back of the paper)

Name:	Dosage:	Reason:

ALLERGIES

Are you allergic to any Medication(s)? Yes No If yes, please list the Medication & Reaction below:

Do you have environmental allergies? Yes No If yes, please list below:

SOCIAL HISTORY

<p>Do you smoke cigarettes?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Less than 1 pack/day</p> <p><input type="checkbox"/> 1-2 packs/day</p> <p>Do you have any plans to quit?</p>	<p>Do you drink alcohol?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how much do you drink a week?</p> <p>Do you plan to quit?</p>	<p>Do you use recreational drugs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what kind of drugs do you use, and how often?</p>
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Marital Status (Check One): Married Single Divorced

How many children (if any): _____

FAMILY MEDICAL HISTORY: (Please check any medical problems that any family member has or had)							
Relative	Diabetes	Alcoholism	Drug Abuse	High Cholesterol	Suicide	Depression	Cancer (Type)
Father							
Mother							
Sibling							
M. Grandmother							
M. Grandfather							
P. Grandmother							
P. Grandfather							
Other							

IMMUNIZATIONS HISTORY		
Have you had this vaccine?		Date of Last Shot
TDAP	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumococcal 23	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pevnar	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Shingles Zoster Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No	1 st Dose:
		2 nd Dose:

PREVENTION	
Date of last Colonoscopy:	
Females Only:	
Date of last Pap examination:	
Date of last Mammogram:	
Last menstrual cycle:	
Are you on Birth Control?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Review of Systems

General				Endocrine	
Weight Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No			Heat/Cold Intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological		Sweating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever/Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head and Neck		Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal	
Earache	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Cramps	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Lightheaded	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunological	
Nasal Drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory		Food Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Genitourinary	
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal		Pain with Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urgency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin		Pain When Urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Nighttime Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Color Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair/Nail Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychological	
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hematology		Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy Bleed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular		Easy Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eyes		Stress	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Redness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck	
Shortness of Breath Upon Waking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular				Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Calf Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No			Lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg Cramping	<input type="checkbox"/> Yes <input type="checkbox"/> No			Swollen Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No



205 E. Hirst Road ■ Suite 200 ■ Purcellville, VA 20132 ■ Ph: 540-338-6101 ■ Fax: 540-338-7803

OFFICE POLICY

WELCOME

We are pleased you have chosen us for your healthcare needs. We are dedicated to giving you the best of care while providing you with support and explanations regarding your condition. We hope this will help answer questions you may have regarding our practice.

LOCATION

We are located on the 2nd floor of 205 E. Hirst Road, Suite 200 in Purcellville, VA. Our phone number is 540-338-6101 and our fax number is 540-338-7803.

REFERRALS

It is the responsibility of the patient to know and understand their insurance policy. Some insurance policies require the member to obtain a referral from their primary care provider before being seen by a specialist. Please allow 72 hours for referrals to be processed. If an office visit is needed before a referral can be issued, you will be contacted by the receptionist to make an appointment.

APPOINTMENTS AND OFFICE & AFTER HOURS

Visits are by appointment and can be scheduled by calling the receptionist at 540-338-6101 between the hours of 8:00 a.m. and 5:00 p.m. Monday – Thursday. If you are unable to keep an appointment, you must call us at least 24 hours in advance or there will be a \$50 no show fee charged to your account which is not billable to your insurance company.

We recognize the importance of prompt review and communication of test results to ensure accurate diagnoses, effective treatment, and optimal patient care. Your provider will determine when it is appropriate for you to schedule a follow-up visit to review any test results and/or manage your care. It is best to schedule your follow-up visit at check-out to ensure that your desired appointment time is available.

PRESCRIPTIONS/REFILLS

All prescriptions and requests for refills will need to be requested during the office visit. If you need a refill and were just seen in the office, please have your pharmacy send the provider a request electronically. This is to ensure the correct medication is being filled.

FORM FEES

Forms needing to be filled out by a provider (i.e., school physical form, disability paperwork) are subject to a \$20 form fee which cannot be billed to your insurance company.

EMERGENCIES

If you feel your condition requires immediate medical attention, go to the nearest emergency room or visit our LMG Immediate Care Center at 46440 Benedict Drive, #107, Sterling, VA 20164. Their phone number is 703-450-1125 or LMG Cornwall Urgent Care at 211 Gibson Street, NW, Suite 215, Leesburg, VA 20176. Their phone number is 571-707-2085.

BILLING AND COLLECTIONS

Payment for office visits, including co-pays, is expected at the time of service. Payment may be made by cash, check, Visa, MasterCard, or American Express. If we participate with your insurance, we will file an insurance claim for your office visit. Inability to pay should be discussed prior to your visit so that acceptable payment arrangements can be made.

Our billing department can be reached at 703-737-6001, extension 6203. Before accounts are forwarded to a collection agency, we send multiple statements, as well as letters to the guarantor/policyholder, allowing ample time for payment arrangements to be discussed. If there is no response, this may result in your account being turned over to a collection agency.

NEW ADDRESS/INSURANCE INFORMATION

Please advise our staff of any new information, especially insurance updates, home addresses, and phone numbers so we may update our records. Having the same information as your insurance company is very critical. Claims submitted to an incorrect insurance provider may be denied due to timely filing issues and may become the patient's responsibility.

DISMISSAL FROM THE PRACTICE

Rarely, it is necessary to dismiss a patient from our practice. However, missing three scheduled appointments, not addressing billing issues, perpetually failing to follow treatment plans as advised, and abuse of the staff are all considered grounds for terminating our relationship.

RELEASE OF INFORMATION

LMG Internal Medicine may disclose any or part of the medical record to my insurance company (or companies) for purpose of satisfying charges billed. I further understand that it may be necessary to contact my past or present employer(s) regarding the insurance claim. For further information, please see the HIPAA release form.

TEST RESULTS POLICIES AND PROCEDURES

Laboratory testing is an important part of a diagnostic evaluation. We encourage you to sign-up to our portal for an immediate access to your lab/diagnostic test results. However, if your test results are reviewed through portal and further question needed, you are required to make a follow-up appointment.

I acknowledge receiving a copy of the Office Policy.

Patient Name: _____ Patient Signature: _____ Date: _____



AUTHORIZATION TO DISCLOSE INFORMATION

Patient's Full Name: _____

SS#: _____

Date of Birth: _____

**INSTRUCTIONS FOR LEAVING MESSAGES
AND/OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION**

OK to communicate with spouse? YES NO
Spouses Name: _____

OK to leave information on answering machine? YES NO

OK to communicate with parent/children? YES NO
Name(s): _____

OK to communicate with caregiver? YES NO
Name: _____

OK to communicate with any other person(s) YES NO

Please list: _____

Communicate only with me YES NO

THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED IN WRITING

Signature: _____

Date: _____

Other Comments: _____
