



LOUDOUN MEDICAL GROUP
IMMEDIATE AND PRIMARY CARE CENTER

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

NAME: (FIRST) _____ (MI) _____ (LAST) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SEX: M OR F STUDENT: Y OR N MARITAL STATUS: S M D W

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ SSN: _____

DATE OF BIRTH: _____ AGE: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMPLOYMENT INFORMATION:

MY EMPLOYER: _____ JOB TITLE: _____

ADDRESS: _____

**IF OTHER THAN PATIENT, RESPONSIBLE PARTY INFORMATION
(MUST BE COMPLETED FOR MINORS):**

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ SSN: _____ DOB: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID#: _____ GROUP#: _____

IF INSURANCE IS IN SOMEONE ELSE'S NAME, PLEASE COMPLETE BELOW: SELF

NAME OF INSURED: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE: _____ DATE OF BIRTH: _____ SSN: _____

INSURED EMPLOYER NAME/ADDRESS: _____

METHODS TO CONTACT YOU:

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
(PLEASE CHECK ALL THAT APPLY):

- HOME TELEPHONE # _____
 - OK TO LEAVE MESSAGE ON HOME ANSWERING MACHINE WITH DETAILED INFO (THIS INCLUDES TEST RESULTS, PRE-OP INFO, FOLLOW UP INFO, ETC.)
 - LEAVE MESSAGE WITH CALL-BACK NUMBER ONLY.
 - DO NOT CALL MY HOME**
- WRITTEN COMMUNICATION
 - OK TO MAIL TO MY HOME ADDRESS
 - OK TO FAX TO THIS # _____
- WORK TELEPHONE # _____
 - OK TO LEAVE MESSAGE WITH DETAILED INFO
 - LEAVE MESSAGE WITH CALL BACK NUMBER ONLY.
 - DO NOT CALL MY WORK**
- CELL PHONE # _____
 - OK TO LEAVE MESSAGE WITH DETAILED INFO
 - LEAVE MESSAGE WITH CALL BACK NUMBER ONLY.
 - DO NOT CALL MY CELL PHONE**
- OTHER: _____

PLEASE BE ADVISED: WE CANNOT GIVE INFORMATION TO ANYONE WITHOUT YOUR WRITTEN CONSENT. IF YOU WANT SOMEONE ELSE (FOR EXAMPLE: YOUR SPOUSE) TO RECEIVE YOUR PERSONAL HEALTH INFORMATION, YOU MUST ASK THE RECEPTIONIST FOR AN AUTHORIZATION FORM. I UNDERSTAND THAT I MAY CHANGE MY METHODS OF CONTACT AT ANY TIME BY WRITTEN CONSENT.

I authorized my insurance benefits to be paid directly to the physician and that I am financially responsible for any balance due. 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 agent, lenders, or any third party service acting for LMG, PC, or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for \$50.00 for any missed appointment of which I did not notify the medical office 24 hours prior to my scheduled appointment.

I authorize LMG, PC 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.

Signature: _____ Date: _____

Print Name: _____