UROGYNECOLOGY CENTER
NORTHERN VIRGINIA

NEW PATIENT HEALTH HISTORY

Name: _____ Date of Birth: _____ Age: _____
Today's Date: _____ Primary Care Doctor: _____ Primary Care Phone: _____
Referring Doctor: _____ Referring Doctor Phone: _____
Preferred Pharmacy Name: _____ City: _____ Phone: _____

CHIEF COMPLAINT
What is the main reason you are seeing the doctor today?

_____
_____

ALLERGIES: (Please list all medication allergies, including shellfish, etc.)
If no allergies, check here: ☐

_____
_____

MEDICATIONS: (Please list all medicines including over-the-counter, supplements and vitamins.)
If no medications, check here: ☐

_____
_____

SURGERIES:

☐ Tonsillectomy	☐ Wisdom Tooth	☐ Appendectomy	☐ D&C
☐ Gallbladder Surgery	☐ Tubal Ligation	☐ C-Section	☐ Hysterectomy
☐ Shoulder Surgery	☐ Vasectomy	☐ Knee Surgery	☐ Laparoscopy
☐ Hernia Repair	☐ Colonoscopy	☐ Other:	

If no prior surgeries, check here: ☐

Weight: _____ Height: _____

FAMILY HISTORY:

	Father	Mother	Brother	Sister	PGF*	PGM*	MGF*	MGM*
Prostate Cancer								
Renal Cancer								
Bladder Cancer								
Testicular Cancer								
Heart Attack								
Heart Disease								
Stroke								
High Blood Pressure								
High Cholesterol								
Diabetes								
Kidney Disease								
Urinary Stones								
Cystic Fibrosis								
Tuberculosis								
Other Cancer Type: _____								
Other Family Hx.:_____								

If there is no family history of any of the above, check here: ☐ If family history is not available, unknown or unobtainable, check here: ☐ * PGF – Paternal grandfather (father's father) PGM – Paternal grandmother (father's mother) MGF – Maternal grandfather (mother's father) MGM – Maternal grandmother (mother's mother)

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PATIENT INFORMATION

LAST NAME	**FIRST NAME**	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	SEX	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please check one)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner	STUDENT *(please check one)* ☐ No ☐ Full Time ☐ Part Time
STREET ADDRESS	CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*	WORK PHONE	CELL PHONE
RACE *(please check one)* ☐ White ☐ Black/African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other Race American ☐ Indian/Alaska Native	ETHNICITY *(please check one)* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	PREFERRED LANGUAGE *(please check one)* ☐ English ☐ Spanish ☐ Other: _____
EMPLOYER / JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
EMAIL ADDRESS		
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(please check one)* ☐ Text Message ☐ Email ☐ Cell Phone ☐ Home Phone		

CONTACT/GUARANTOR INFORMATION

CONTACT *(please check at least one)* ☐ Emergency Contact ☐ Next of Kin ☐ Insured ☐ Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER	WORK PHONE	JOB TITLE	

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please check at least one)* **Guarantor** ☐ Emergency Contact ☐ Next of Kin ☐ Insured ☐ Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* / DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER	WORK PHONE	JOB TITLE	

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INSURANCE POLICY INFORMATION

POLICY NUMBER	**GROUP ID**		EFFECTIVE DATE
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	**INSURANCE COMPANY ADDRESS**		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSICIAN (PCP) &/OR REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE *(please check only one)* ☐ Health ☐ Auto ☐ Worker's Comp. ☐ Other	PRIMARY INSURANCE? *(please check one)* ☐ Yes ☐ No	END DATE	COPAYMENT AMOUNT Office: $_____ Specialist: $_____
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE

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.

_____ _____
Print Name Date

_____
Signature

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:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or 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.

2. 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.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it.

_____ _____
Signature of Patient, Parent/Legal Guardian Date

_____
Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

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NORTHERN VIRGINIA

OFFICE POLICIES

Billing

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable co-pay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. If you do not have your insurance information available at the time of your visit, we require that you pay 100% of charges rendered prior to the visit.

If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to over to a collection agency. In addition to the principle balance due, you will also be responsible for any legal or collection agency fees incurred.

Cancellations

We will attempt to contact you to remind you of your appointment 24 hours prior to your appointment. If you are unable to keep your appointment, we require a 48 hour notice of cancellation. If you fail to show for your appointment or cancel without notifying us 24 hours in advance, we reserve the right to charge you a $40.00 no show fee. Fees for procedures/surgery may vary.

If you are 15 minutes late to your appointment, you may be asked to reschedule and you may incur a fee.

Prescription Refills

We request 72 hours to refill prescriptions from time of request. The best way to request refills is to call your pharmacy two (2) weeks before your medication runs out.

Referrals/Prior Authorizations

Please call your insurance to verify if a referral/prior authorization is needed. Some insurance companies do not require a referral. Please allow at least 72 hours to obtain your referral. Some insurance's can take up to 7 business days to receive approval or denial. We cannot back date referrals and we cannot accommodate same day referrals unless it is a true emergency.

Forms/Medical Records

Forms needing to be filled out by a provider (i.e. school physical form, disability paperwork) are subject to a $10-$50 form fee which cannot be billed to your insurance company. Please allow us 72 hours for the forms to be completed. There will be a $10 fee for lost orders/referrals.

After Hours Care

You can reach the on call physician by calling our main office number. The on call physician will advise you where to go based on your medical condition.

Emergencies

If you have a life-threating emergency, please call 911 or go to your nearest emergency room.

By signing this form, I have agreed to the terms and conditions listed above.

Printed Patient Name	Date of Birth	Today's Date

Patient Signature

Printed Name of Personal Representative	Relationship to Patient	Signature of Personal Representative

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NORTHERN VIRGINIA

PERMISSION TO DISCLOSE INFORMATION

I, _____, acknowledge that I was made aware of Urogynecology Center of Northern Virginia/Loudoun Medical Group's Privacy Policy and a copy was made available to me for my review.

I authorize Urogynecology Center of Northern Virginia to disclose my protected health information to the following person(s) and entities:

Name	Date of Birth	Relationship to You

_____ _____
Printed Patient Name Today's Date

_____
Patient Signature

_____ _____
Printed Name of Personal Representative Relationship to Patient

_____
Signature of Personal Representative

NOTIFICATION OF TEST RESULTS

In most cases, you will be notified by phone of your test results. Please ensure the phone number we have on file for you is correct.

Preferred phone number: _____

May we leave a detailed message at this number? ☐ Yes ☐ No

Patient Name: _____ Patient DOB: _____

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

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

_____
Relationship (if any)

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LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient's Name

I have a 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) **Other:**