LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Completed Date: _____

PATIENT INFORMATION

Personal Information

Prefix: Mr./Mrs./Other: _____ Patient*: _____

Suffix: Jr./Sr./Other: _____
Last First Middle Initial

Previous Name: _____ Preferred Name: _____

Mailing Address:

_____
Street Address City State Zip

Home #: _____ Cell #: _____ Work #:_____

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

Primary Care Provider/Doctor (PCP): _____ Phone #: _____

Date of Birth*: _____ Sex*: _____

mm/dd/yyyy
Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ - _____ - _____ Employer Name: _____

Occupation: _____
Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired

Emergency Contact*
Name:_____ Relationship: _____
Last First

Home #: _____ Work #: _____ Cell #:_____

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Referred by: __ Google __ Facebook __Yelp __Zocdoc __ friend __Other[_____]

Pharmacy Name : _____Address:_____

RACE*:

☐ Caucasian/White

☐ African American

☐Asian

☐ Hawaiian/Pacific Islander

☐ Other: _____

Ethnicity*:

☐ Hispanic or Latino

☐ Non-Hispanic or Latino

☐ Other: _____

Language*:

☐ English

☐ Spanish

☐ Other: _____

Sexual orientation and Gender Identity:

- ☐ Lesbian, gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Do not know
- ☐ Choose to not disclose

- ☐ Male
- ☐ Female
- ☐ Female to Male[FTM] Trans Man
- ☐ Male to Female[MTF] Trans Woman
- ☐ GenderQueer
- ☐ Choose to not disclose

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. **X _____ (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. **X _____ (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 transit 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. **X _____ (Please initial)**

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through Dr. First. 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. **X _____ (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 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:**

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Patient Name: _____ Patient Date of Birth: _____

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 devise 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)