LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

LOUDOUN MEDICAL GROUP

DEMOGRAPHICS

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

CONTACT/GUARANTOR INFORMATION

CONTACT *(please circle 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 circle 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	

INSURANCE POLICY INFORMATION

Over

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? 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 PHYSCIAN (pcp) &/or REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? 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, or Person Acting in Loco Parentis **Date**

_____

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

224-D Cornwall St. NW • Suite 301
Leesburg, Virginia 20176
(703) 779-0700
Fax: (703) 779-1398

POTOMAC
FAMILY PRACTICE

46165 Westlake Drive • Suite 120
Potomac Falls, Virginia 20165
(703) 444-3302
Fax: (703) 444-3240

Welcome to Potomac Family Practice! We are pleased you have chosen us for your Family Care needs. We are dedicated to giving you the best of care while providing you with support and explanations regarding your condition.

APPOINTMENTS

Visits are by appointment and can be scheduled by calling the front desk. To better accommodate our patients, Dr. Truong offers early hours starting at 7a.m. Monday-Thursday in both the Sterling and Leesburg locations. ***If you are unable to keep your appointment, you must call at least 24 hours prior to your appointment or there will be a $50 no show fee charged to your account which is not billable to your insurance.**

REFERRALS

It is the responsibility of the patient to know and understand their insurance policy. Some insurances require the member to obtain a referral from their primary physician before seeing a specialist. Referrals can be obtained by speaking to the front desk or leaving a voice message on our referral line. ***Phone referrals can only be completed if you have seen your primary physician for the condition within the past 6 months. If it has been over 6 months an office visit will be required.** Please allow 72 hours for referrals to be processes. Unfortunately, we do not backdate referrals.

PRESCRIPTION / REFILLS

All prescriptions and refill requests should be requested during normal office hours by calling and speaking to a nurse or by having your pharmacy fax us a refill request. Please have your pharmacy telephone number, prescription name and dosage close at hand. ***After hours prescription requests will not be filled until the next business day.**

FORM FEES

Forms needing to be filled out by the provider (i.e. school forms, physical forms, disability paperwork) are subject to a $10-$50 fee which cannot be billed to your insurance company. Also, any forms dropped off to office without an office visit will be charged a fee. Please allow 3-5 business days for the forms to be completed. ***Fees are dependent upon the nature of the form and are charged at the discretion of the provider.**

Over >

EMERGENCIES

In the event an emergency occurs after business hours, please call the after-hours line at 703-755-1410. Phone consults are subject to a $10-$20 fee which will be billed to the patient directly as they cannot be billed to your insurance company. ***Please keep in mind that after hours calls are for emergent problems only.** If you feel your condition requires immediate medical attention, please go to the nearest emergency room or visit out LMG Immediate Care Center at 46440 Benedict Drive #107, Sterling, VA 20164. Their phone number is 703-450-1125.

BILLING AND COLLECTIONS

Payment for office visits, including co-pays and balances, is expected at the time of service. Payment may be made by cash, check, Visa, MasterCard, Discover or American Express. A $30 insufficient fund fee will be applied to any returned checks.

If we participate with your insurance we will file an insurance claim for your office visit. Unfortunately, we do not submit to third party payors, such as motor vehicle insurance. ***Routine labs are not covered under Medicare insurance. *If you have general Medicaid, we will refer you to the VA Health Department for vaccines as they are not a covered benefit.**

For all billing inquiries, please contact our billing department at 703-737-6001, option 2.

RECEIPT OF OFFICE POLICY

I, _____, acknowledge receiving on _____,
Print Patient Name Date

a copy of the Potomac Family Practice office policy.

_____ _____
Patient Signature Date

As your personal provider, my responsibilities are:

Explain diseases, treatment, and results in an easy-to-understand way. Listen to your feelings and questions which will help us make decisions about your care. Keep your treatments, discussions, and records confidential. Provide same day appointments whenever possible. Provide instructions on how to meet your health care needs when our office is not open through the answering service which provides 24-hour access to medical care. Give you clear directions about medicine and other treatments. Send you to a trusted specialist, if needed. End every visit making sure you have clear instructions about expectations, treatment goals, and future plans.

As our patient, your responsibilities are:

Asking questions, sharing your feelings, and taking an active part in your care. Being honest about your history, symptoms, and other important information, including any changes in your health and wellbeing. Taking all your medicine as directed. Inform us whenever there is a problem with the medication you are taking. Making healthy decisions about your daily habits and lifestyle. Keeping your scheduled appointments or reschedule in advance whenever possible. Calling our office first with your health concerns, unless it is an emergency. Being sure you leave our office with a clear understanding of our expectations, treatment goals and future plans.

As a patient in a medical home, I acknowledge my care is in collaboration with my primary care provider and the care team.

I agree to bring all information that pertains to my health created at another healthcare facility including, but not limited to:

- Ophthalmologic Testing (i.e., eye exams)
- Foot Exams
- Imaging Results
- Bloodwork
- Hospital Discharge Information
- Specialist Reports

Patient's Name DOB

Patient's Signature Date

Thank-You for Choosing Loudoun Medical Group.

The Mission of LMG is to provide compassionate, family-centered healthcare in a warm and friendly, hometown environment.

Loudoun Medical Group

224-D Cornwall Street NW, Suite 403
Leesburg, VA 20176

703.737.6010

Visits us online at:
www.lmgdoctors.com

Patient Centered *Medical Home*

LMG LOUDOUN MEDICAL GROUP

One Group. Infinite Possibilities.

Patient-Centered Medical Home

A Patient-Centered Medical Home (PCMH) is not a building, house, or hospital, but rather an approach to providing comprehensive health care.

A Medical Home is called a "Home" because we'd like this office to be the first place you think of for all your medical needs. Our goal is to make it easy and comfortable to get the care you need in a way that works best for you.

As your healthcare provider, we are here to facilitate a personal partnership with you and your family to provide you with the best quality, comprehensive, and progressive primary care.

Why are the Loudoun Medical Group Offices becoming PCMH's?

Our culture is one of continuous improvement with the result of providing high quality of care for all the patients we serve. We believe the Patient Centered Medical Home model will help us do this. By positioning your physician to provide, oversee, and coordinate all the care you need, the PCMH model seeks to strengthen the provider-patient relationship. It will replace episodic care based on symptoms and illnesses with coordinated, whole person care and long-term healing relationships. As our patient, you will enjoy an ongoing relationship with a personal provider. Your physician leads a team that takes collective responsibility for your care. The Medical Home also provides enhanced care through open scheduling, expanded hours, and fostering communication amongst patients, providers, and staff.

Joint Principles of the Patient-Centered Medical Home

Personal Provider - Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous, comprehensive care. In addition, your personal provider leads a team of individuals who collectively take responsibility for your ongoing care.

Whole Person Orientation - Your personal provider is responsible for providing all your health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventative services, and end of life care.

Care is coordinated or integrated - Your provider and healthcare team will coordinate your care with other elements of the health care system, such as subspecialty care, hospitals, home health agencies, and nursing homes. They are also equipped to integrate this care with your family and any public or private community services that you may currently use or that may be of benefit to you. Your Patient Centered Medical Home uses a vast array of information technology, registries, health information exchange, etc... to make sure you get the care you need when and where you need it.

Quality and Safety - By centralizing your care in one place, the potential for errors is minimized. Moreover, by putting the focus on you, our patient, the quality of care is enhanced.

Enhanced Access to Care - Open scheduling, expanded hours and new options for communication between patients, their personal provider and practice staff (e.g. web-based patient portal) makes it easier and quicker to get the care you need

The health and wellness of our patients is the #1 priority of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, your provider, and you, my patient, work together. This is the basis behind the Patient-Centered Medical Home.

46165 Westlake Drive
Suite 120
Potomac Falls, VA 20165
Phone: 703-444-3302
Fax: 703-444-3240

POTOMAC

224-D Cornwall Street, NW
Suite 301
Leesburg, VA 20176
Phone: 703-779-8700
Fax: 703-779-1398

www.potomacfamilypractice.com

INSURANCE WAIVER

PRIVATE, COMMERCIAL AND MEDICARE INSURANCES

Medicare and or your private insurance carrier will only pay for services that it determines to be 'reasonable and customary" under Section 1862 (a) (1) of the Medicare law.

Medicare will not cover any routine physical or routine lab work. Medicare will only cover one well woman exam every two years.

It will be the patient's responsibility to verify that your insurance will cover any procedure that you are requesting to be done.

Private and commercial insurances will deny coverage for the following reasons:

A. Potomac Family Practice is not listed as the PCP
B. Patient is not listed as a covered dependent on said plan
C. Patient policy has terminated at time of service and/or patient did not present front desk with a current insurance card.
D. Patient went to a non participating facility for any lab or tests, it is patient responsibility to verify correct lab and/or facility for tests
E. Insurance will only cover a limited amount toward a routine physical and/or labs
F. Routine physicals are only allowed every year or every other year depending on your insurance coverage
G. School, Sports and any other third party physicals are not a covered benefit under any insurance plan

If Medicare and/or my commercial insurance should deny any or all charges then I agree to be personally and fully responsible for any and all balances due.

Printed Name_____

Patient Date of Birth_____

Signature_____

Today's Date_____

(For Anthem Healthkeepers) Reason for visit_____
Estimated Cost of Appointment_____

LOUDOUN MEDICAL GROUP / POTOMAC FAMILY PRACTICE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

DOB: _____ SS#: _____

Home Phone: _____ Cell Phone: _____

As required by the HIPPA privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

ADDITIONAL CONTACT INFORMATION

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following person(s), entities, or caregivers:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give Potomac Family Practice permission to leave my results or any pertinent medical information on my home voicemail or cell phone. **Home / Cell / Both**

My signature verifies that this request accurately reflects my wishes. I understand that this is valid for 1 year from the date of signature. It is my responsibility to notify Potomac Family Practice of any changes prior to the expiration of this form.

_____ _____

Signature Date

I understand that I have the right to: revoke this authorization at any time by giving written notice to the office, receive a copy of this authorization and restrict what is disclosed, inspect a copy of the patient health information being used for disclosure under the federal law.