

LOUDOUN FAMILY MEDICINE, P.C.

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Lansdowne, VA 20176

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S E V C S

PATIENT REGISTRATION FORM

New Patient: _____
Change of Information: _____

Patient Information:

Patient's Name (Last) _____ First _____ MI _____

Parent Name (if minor) _____

Address _____ City _____

State, ZIP Code _____ Sex (M/F): _____ S.S.#: _____

Birth Date: _____ Home Phone #: _____ Cell Phone #: _____

Work Phone (Parents or Spouse) _____ Email: _____

Patient Employer _____ Referring Physician _____

EMERGENCY CONTACT _____ Relation _____ Phone #: _____

How did you hear about us? Google Yahoo Yellow Book Other Search Engine Television Other _____

Responsible Party:

Policy Holder's Name _____

Address _____ City, State, ZIP code _____

Patient Relation to Guarantor _____ Guarantor Employer _____

Home Phone #: _____ Cell Phone #: _____ Employer's Phone #: _____

Employer's Address _____ City, State, ZIP code _____

Policy Holder's S.S.#: _____ Birthdate _____ Sex(M/F) _____

Primary Insurance:

Name of Insurance Company _____ Policy Holder _____

Pt. Relation to Policy Holder _____ Policy #: _____ Group #: _____

Insurance Co. Address _____

Insurance Co. Phone #: _____ Policy Holder's Birth Date _____ Sex(M/F) _____

Secondary Insurance:

Name of Insurance Company _____ Policy Holder _____

Pt. Relation to Policy Holder _____ Policy #: _____ Group #: _____

Insurance Co. Address _____

Insurance Co. Phone #: _____ Policy Holder's Birth Date _____ Sex(M/F) _____

I (patient/guarantor), the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics, the performance of such procedures as may be deemed advisable in the treatment of this patient, the use of prescribed medication, the performance of diagnostic procedures, the taking and utilization of cultures and performance of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their designees, may be considered medically necessary or advisable.

I fully understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in force until revoked in writing.

Date of Service _____

Initials _____

I (patient/guarantor) hereby authorize LOUDOUN FAMILY MEDICINE P.C. (LFM) to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to LFM of benefits otherwise payable by me. I hereby authorize LFM to release my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization or otherwise by any third party payor. If my insurance requires a selection of a Primary Care Physician (PCP) and I have not selected LOUDOUN FAMILY MEDICINE, P.C or one of its physicians, or have not obtained the proper referral, I agree that I am financially responsible for those fees and will pay the same in accordance with the terms of each invoice. A photocopy of this authorization shall be considered as valid as the original. I further acknowledge that I am indebted for past due charges and I understand that I am financially responsible for those charges as well, and agree to pay the same.

Medicare Patients: I (patient/guarantor) authorize LOUDOUN FAMILY MEDICINE, P.C. to release medical information about me/patient to the Social Security Administration or its intermediaries for my Medicare claims. I hereby assign the benefits payable for services to LOUDOUN FAMILY MEDICINE, P.C.

In accordance with the provisions of Section 32.1-45.1 of the code of Virginia, (whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to current guidelines of the Centers of Disease Control, transmit HIV), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus. If there is an exposure, and the patient’s test is positive, the attending physician will notify the patient, any person exposed, the Virginia Health Department and appropriate counseling will be offered.

Patient Responsibilities and Office Policies:

- 1. It is the patient’s responsibility to know your insurance policy and understand your benefits. It is the patient responsibility to make sure specific laboratory, outpatient radiology facility; inpatient radiology facility or consultant physician accepts your insurance. It is the patient responsibility to understand your policy benefits and know what is covered and not covered. It is patient’s responsibility to inform all insurance changes at the time of service. I as a patient/guarantor of patient am/is, aware that health insurance may not cover the service that the patient receive from Loudoun Family Medicine, P.C., because the patient have
 - a) not presented with insurance card or,
 - b) presented an insurance card which bears the name of a Physician, listed as patients’ primary care physician (PCP), who is not affiliated with Loudoun Family Medicine, and need referral from patients’ Primary care Physician.

I have been informed that I must :

- a) present active insurance card to Loudoun Family Medicine, P.C. within two(2) working days or
- b) contact my insurance company to make sure that my primary care physician has indeed been updated to reflect a Loudoun Family Medicine, P.C. physician(s), and that a new card bearing such information has been issued.
- c) get **referral** with (if needed) an appropriate prior authorization for visit from my Primary Care Physician for services provided by the physician at Loudoun Family Medicine, P.C.

If the update has not been made, or if I do not present my insurance information and referral with appropriate prior authorization in a timely manner, I understand that I am fully responsible for all charges incurred as a result of visit/s at Loudoun Family Medicine, P.C.. Physicians at Loudoun Family Medicine, P.C. do offer urgent care services in office on walk-in basis as well as perform physicals and appointment for establish patient but will be billing insurance companies as primary care providers.

- 2. Referrals require up to 72 hours to process. Your referral can be picked up or faxed. If you choose to pick up your referral, you will be called when it is ready. Referrals can only be done on the same day for medical emergencies.
- 3. In order to get medical records it may take up to 7days to be copied. LOUDOUN FAMILY MEDICINE P.C. will charge for coping of medical records.
- 4. Co-payments must be paid prior to each visit. This is required in terms of your contract with your insurance company. Forms of payment accepted are cash, VISA, Mastercard, money order, or check.
- 5. Patients must present with appropriate insurance information or the patient will be considered self-pay for the full cost of the visit. Patients with coverage requiring a Primary Care Physician must have an appropriate physician on their card at the time of the service. If any of the above information is missing, the patient must obtain it within 20 minutes of the scheduled appointment time or sign waiver indicating financial responsibility for the visit.
- 6. After hours calls to our on-call physician are reserved for emergencies only. If you feel you need to go to ER after our office hours for anything that is not obviously life threatening you may first need to contact the on call physician for authorization. Failure to do so may result in a rejection of payment from your insurance company.

Initials _____

- 7. Prescription refills require 24 hours to be processed. Please call your pharmacy and request that they fax us a refill request.
- 8. This office will file all primary insurance claims. Secondary claims will be filed for Medicare and Medicaid patients. Secondary claims for other carriers will be mailed to the patient with a copy of the primary carrier’s explanation of benefits.
- 9. Patient bills are mailed once a month. Payment in full is due within 30 days. Balances over \$50 can be paid at a minimum of 20% of the total account balance per month. A \$25 late fee will apply to all accounts when the minimum amount due is not paid within 30 days. Payment plans are available on current accounts. Payment arrangements must be made with the billing manager prior to service for overdue accounts.
- 10. Accounts greater than 60 day past due are eligible for collection activity. Patient will be notified of such action and it is the patients’ responsibility for all collection and late fees incurred.

Notice of Privacy Practices: (Medical Information Disclosure – Summary of Office Policy)

You are strongly encouraged to carefully read the entire “Patient’s Right and HIPPA Notice” and not to rely on this summary of your rights. LOUDOUN FAMILY MEDICINE, P.C. may use and disclose your health information for the following purposes: to provide treatment, to obtain payment, for quality assurance, to conduct health care operations, for appointment reminders, for treatment alternatives, when disclosure is legally required, when there are risks to public health, to report abuse, neglect, or domestic violence, to conduct health oversight activities, for law enforcement purposes, to coroners and medical examiners, for organ, eye, or tissue donation, and for research purposes. In any other situation, we will ask for your written authorization before disclosing any specific health information about you.

LOUDOUN FAMILY MEDICINE, P.C. is required by law to maintain the privacy of your health information and to provide to you and your representative notice of its duties and privacy practices (see our Patient’s Right and HIPPA Notice). LOUDOUN FAMILY MEDICINE, P.C. is required to abide by the terms of that Notice as may be amended from time to time. We reserve the right to change the terms of our Notice and to make the new Notice provisions effective for all health information that it maintains. If we change our Notice, we will provide a copy of the revised Notice to you or your appointed representative. You or your personal representative have the right to express complaints to this office and to the Secretary of DHHS if you or your representative believe that your privacy rights have been violated. LOUDOUN FAMILY MEDICINE, P.C. encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Results Policy:

It is our policy to discuss your lab and radiology results at your follow up appointment or by phone. If you have not had your follow up appointment or received a phone call please call us so that we may obtain these reports from appropriate facilities where testing performed for you/dependent.

I have reviewed my patient’s rights and responsibilities and privacy policies. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PATIENT/PARENT SIGNATURE (or responsible party) _____ **Date** _____

IF MINOR NAME OF THE CHILD: _____