**LOUDOUN MEDICAL CARE & WELLNESS, 19490 Sandridge Way, Suite 210, Lansdowne 20176**

**DEMOGRAPHICS**

| | | |
|---|---|---|
| LAST NAME | FIRST NAME | MIDDLE INITIAL |
| SOCIAL SECURITY NUMBER | SEX | PREFIX/SUFFIX |
| DATE OF BIRTH *(mm/dd/yy)* | STATUS *(please circle one)*<br>Single Married Divorced Widowed Partner | STUDENT *(please circle one)*<br>No Full Time Part Time |
| STREET ADDRESS | CITY/STATE | ZIP CODE |
| HOME PHONE *(include area code)* | WORK PHONE | CELL PHONE |
| RACE *(please circle one)*<br>White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native | ETHNICITY *(please circle one)*<br>Hispanic or Latino Not Hispanic or Latino<br>Unknown | PREFERRED LANGUAGE<br>English Spanish<br>Or other:<br>_____ |
| Referred by(name):<br>_____<br>Family, Friend, Internet, Radio, Other_____ | EMPLOYER/ ADDRESS:<br>EMPLOYER PHONE NUMBER : | |

| | | |
|---|---|---|
| PREFERRED PHARMACY | PHARMACY PHONE NUMBER | EMAIL ADDRESS |

**CONTACT/GUARANTOR INFORMATION**

| | | | | |
|---|---|---|---|---|
| CONTACT ***(please circle at least one)***<br>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)*<br>**Guarantor**<br>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**

| POLICY NUMBER | GROUP ID | | EFFECTIVE DATE |
|---|---|---|---|
| TYPE (please circle one only)<br>Health Auto Work. Comp.<br>Other | PRIMARY INSURANCE?<br>Yes No | END DATE | COPAYMENT AMOUNT<br>Office: $_____ |
| 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)<br>Health Auto Work. Comp.<br>Other | PRIMARY INSURANCE?<br>Yes No | END DATE | COPAYMENT AMOUNT<br>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 payer, health maintenance organization, insurer or other health benefit plan. This consent applies to Loudoun Medical Care & Wellness, or any of its affiliates or agents, lenders, or any third party servicer acting for Loudoun Medical Care & Wellness, or any of its affiliates /agents.*

***RELEASE OF INFORMATION***

**I hereby give permission to the person(s) listed below to receive information about the care of the above named patient.**

**Name(s):** _____

**Relationship to Patient:** _____

**Patient Name:**_____ **Date:** _____

**Signature of patient or Guardian :** _____

5. Insurance.**5. Insurance.LOUDOUN MEDICAL CARE & WELLNESS**

**Patient Responsibilities and payment policies**

Welcome to my practice. We are committed to providing you with quality and affordable health care. We have developed this form to help our patients understand patient and insurance responsibility for services rendered in our office Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Please notify us any change in your address or insurance promptly

2. Call 24 hours before your scheduled appointment if you need to cancel or reschedule an appointment. There is a $50.00 fee for all missed or canceled physicals, and $25.00 for all missed and canceled office visits without a 24-hour notice.

3. Co-payments, Co-Insurances, and all overdue bills must be made at the time services are rendered. Balances must be paid in an appropriate time.

4. **Proof of insurance.** All patients must complete our patient registration form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5. Insurance.** Loudoun Medical Care & Wellness has applied to participate in several insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business and Loudoun Medical Care & Wellness has not yet been credentialed with that insurance, you will pay your fee at the time of visit and and Loudoun Medical Care & Wellness has not yet been credentialed with that insurance, you will pay your fee at the time of visit and Loudoun Medical Care & Wellness will provide you a receipt , so you can submit to your insurance and claim that fee. You also understand and agree that you are financially responsible for changes not paid by your insurance policy. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

**6. Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**7. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

8. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. There is $25.00 fee on all returned checks. Please resolve billing issues before your next appointment.

10. Tests will be ordered by the Physician that is medically necessary. It is your sole responsibility to contact your insurance company to determine the facilities you can use and to notify us.

11. It is necessary for you to know the correct lab you could use based on your insurance company.

12. When you need referrals please notify us forty eight hours or more before you need them. If your Insurance requires a prior authorization for services or medications, notify us three business days or earlier to process it. We will not back date

any referrals and we will not fax or mail any referrals. You must pick the referral from our business office. If your insurance company requires you have a referral and you do not, you are responsible for that bill.

13. There is a fee for copying medical records. We charge a processing fee of $10.00 and 0.50 cents per page, not to exceed $30.00 per patient.

14. Unless otherwise stipulated by the Physician, please wait 7 days after your test is performed to call us for your results. Your doctor may ask you to schedule a follow-up appointment to discuss test results. We will not be able to give certain test results over the phone and also will not be able to inform anyone other than the patient of results without their prior approval.

15. For Prescription refills please contact your pharmacy first, so they can contact us. We require 48 business hours from the time of your request to process refill. Written prescription will be ready for pickup 48 business hours after request.

16. Please make sure you return for follow-up appointments in the time frame stipulated by your physician. Narcotics and Benzos like Xanax will not be prescribed as a long term medication. After 30 days if you need more of these medications we advice you see pain specialist or appropriate specialist and establish care with them for these medications. Please call or see us before the 30 days of your prescription run out to sort these out. We will not mail or fax any prescription.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and patient responsibilities and I agree to abide by its guidelines:

Patient Name: _____

Patient / Parent Signature: _____ Date: _____

Name of the Parent: _____

## Acceptance of Privacy Policy

I have been given a copy of the Loudoun Medical Care & Wellness Notice of Privacy Practices as required by the Health Information Portability & Accountability Act of 1996. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Loudoun Medical Care & Wellness health care operations. The Notice also describes my rights and Loudoun Medical Care & Wellness duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration areas and will be provided upon request to the receptionist.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian, if applicable