Virginia Heartburn & Hernia Institute

PATIENT INFORMATION FORM

(Please make sure to print clearly and sign at the bottom of this page)

Prefix:Mr/Mrs/Other:_____ Patient Name*:_____ Suffix:Jr/Sr/Other:_____
(Last / First / Middle Initial)

Previous Name:_____ Preferred Name:_____ E-Mail:_____

Date of Birth*:_____ Birth Sex*:_____ Marital Status*: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced
(mm/dd/yyyy)

Mailing Address*:_____
(Street Address / Apt# / City / State / Zip)

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

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

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

Primary Care Provider(PCP):_____ Phone #:_____
(First / Last)

Referring Provider:_____ Phone #:_____
(First / Last)

Pharmacy Name*:_____ City:_____ Phone #:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Race*: ☐ Caucasian/White ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ Other:_____

Sexual Orientation: ☐ Lesbian/Gay/Homosexual ☐ Straight/Heterosexual ☐ Bisexual ☐ Don't Know ☐ Decline to Specify ☐ Other:_____

Ethnicity*: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Gender Identity: ☐ Male ☐ Female ☐ Female-To-Male(FTM)/Transgender Male/Trans Man ☐ Male-To-Female(MTF)/Transgender Female/Trans Women ☐ Genderqueer, neither exclusively male nor female ☐ Decline to Specify ☐ Other, please specify_____

Language*: ☐ English ☐ Spanish ☐ Other:_____

Emergency Contact*:

Name:_____ Relationship:_____
(Last / First)

Address:_____
(Street Address / Apt# / City / State / Zip)

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

Parent/Guardian Information* - Required if the patient is under 18 years of age

Name:_____ Date of Birth:_____ Birth Sex:____ Social Security#:_____-_____-_____
(Last / First / mm/dd/yyyy)

Address:_____
(Street Address / Apt# / City / State / Zip)

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

Primary Insurance Information*

Insurance Name:_____ Member ID:_____ Group:_____

Employer:_____ Effective Date:_____

Insured's Information* -(if not self)

Name:_____ Date of Birth:_____ Birth Sex:____ Social Security#:_____-_____-_____
(Last / First / mm/dd/yyyy)

Relationship to Insured:_____ Martial Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address:_____
(Street Address / Apt# / City / State / Zip)

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

Secondary Insurance Information*

Insurance Name:_____ Member ID:_____ Group:_____

Employer:_____ Effective Date:_____

Insured's Information* -(if not self)

Name:_____ Date of Birth:_____ Birth Sex:____ Social Security#:_____-_____-_____
(Last / First / mm/dd/yyyy)

Relationship to Insured:_____ Martial Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address:_____
(Street Address / Apt# / City / State / Zip)

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

Medical Questionnaire **Patient Name:**_____ **DOB:**_____

Social History:

Are you a current Smoker? ☐ Yes ☐ No

Have you ever been a smoker? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If so, how often do you drink?_____

Do you currently use any recreational drugs? ☐ Yes ☐ No

If yes, for how long have you been using?_____

CURRENT MEDICATIONS:(please list all medications, including those without a prescription)

Medication:	Dosage:	Medication:	Dosage:
1		6	
2		7	
3		8	
4		9	
5		10	

ALLERGIES: (please list)

Drug:	Reaction/Symptoms	Environmental:	Reaction:
1		Latex Allergy? ☐ Yes ☐ No	
2		Iodine Containing Components? ☐ Yes ☐ No	
3		IV Dye? ☐ Yes ☐ No	
4		Food?	
5		Other:	
6		Metal Allergy? ☐ Yes ☐ No	

ADDITIONAL HISTORY:

☐ VRE	☐ Clostridium Difficile	☐ Hepatitis B	☐ Hepatitis C
☐ HIV Infection	☐ MRSA	☐ Tuberculosis	☐ Other:_____

SURGERIES:

1	Year:
2	Year:
3	Year:
4	Year:
5	Year:

FAMILY HISTORY: Please **X** the box if there is a history in your family

Member	Father	Mother	Paternal Side	Maternal Side	Children	Siblings
Status (alive, decease, unknown)						
Year of Birth						
Age						
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hypertensions	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please answer in the space provided

# of Siblings:	Brothers		Sisters		Healthy? ☐ Yes ☐ No
# of Children:	Sons		Daughters		Healthy? ☐ Yes ☐ No

Notes:

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Belching
- ☐ Diarrhea
- ☐ Flatulence
- ☐ Gastroesophageal Reflux
- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Vomiting
- ☐ Hiccups

If Yes, Explain

_____

Respiratory:

- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chest Congestion
- ☐ Chest Tightness
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Tuberculosis Exposure
- ☐ Sleep Apnea

If Yes, Explain

_____

Musculoskeletal:

- ☐ Muscle Weakness
- ☐ Muscle Pain
- ☐ Muscle Cramps
- ☐ Osteoporosis

If Yes, Explain

_____

Dermatologic:

- ☐ Cellulitis
- ☐ Skin Growths
- ☐ Herpes Simplex
- ☐ Lesions
- ☐ Skin Cancer
- ☐ Recurring Infections

If Yes, Explain

_____

Cardiovascular:

- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ Varicose Veins
- ☐ Arrhythmia
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Myocardial Infraction
- ☐ Peripheral Vascular Disease

If Yes, Explain

_____

Urologic:

- ☐ Painful Urination
- ☐ Flank Pain
- ☐ Urinary Incontinence
- ☐ Chronic/Acute Renal Failure
- ☐ Blood in Urine
- ☐ Impotence
- ☐ Frequent Urination

If Yes, Explain

_____

Hematologic:

- ☐ Anemia
- ☐ Clotting Disorders
- ☐ Prolonged Bleeding Time
- ☐ Slow Wound Healing
- ☐ Venous Thrombosis
- ☐ Arterial Thrombosis

If Yes, Explain

_____

Pyschiatric:

- ☐ Addiction
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Mania

If Yes, Explain

_____

- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

If Yes, Explain

_____

Endocrine:

- ☐ Adrenal Disorders
- ☐ Diabetes Insipidus
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidsm
- ☐ Goiter
- ☐ Renal Failure

If Yes, Explain

_____

Head/Ear/Nose/Throat

- ☐ Recent Change in Taste
- ☐ Nasal Drainage
- ☐ Snoring
- ☐ Vision Problems
- ☐ Postnasal Drip
- ☐ Hoarseness
- ☐ Difficulty Swallowing

If Yes, Explain

_____

Neurologic:

- ☐ Seizures
- ☐ Alteration of Consciousness
- ☐ Sudden Loss of Consciousness
- ☐ Chronic Pain
- ☐ Headaches/Migraines
- ☐ Confusion
- ☐ Dizziness
- ☐ Tremors
- ☐ Memory Loss
- ☐ Mental Status Change
- ☐ Numbness
- ☐ Muscles Weakness
- ☐ Tingling Sensations

If Yes, Explain

_____

General:

- ☐ Feeling Tired(fatigue)
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain

If Yes, Explain:_____

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 settle meant 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 results 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 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. **X_____(Please initial)**

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 side 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 eternal connected sites.

MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudon Medical Group to:

- Determine the pharmacy benefits and drugs 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 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 medication prescribed for patient by any provider.
- Also, this is notice that Loudon 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 provides 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)

PATIENT FINANCIAL POLICY

It is the responsibility of the patient to keep all insurance and demographic information up to date. Co-payments are expected at the time of the visit as well as any deductibles, co-insurance payments, or payment for any non-covered services.
If a referral is required for your visit, it is the sole responsibility of each patient to arrive with that required referral. If you do not have the required referral at the time of your appointment, payment will be due at the time of service.
A fee of $30.00 will be assess for returned checks. ‘

I hereby authorize Virginia Heartburn & Hernia Institute to apply for benefits for services rendered. I certify that the information that I have provided with regard to insurance coverage is correct. I further authorize the release of any necessary information including medical, for any related claim to my insurance carrier in order to determine benefits payable. I request that payment of authorized benefits be made payable to Virginia Heartburn & Hernia Institute.

I understand that i am financially responsible for the total charges for services rendered which may include non-covered services. I agree that all amounts are due upon request and are payable to Virginia Heartburn & Hernia Institute. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of Virginia Heartburn & Hernia Institute.

I have read the above Patient Financial Policy and have provided true and correct insurance and demographic information. I will promptly notify you of any changes to my health insurance carrier including new ID #’s with my current carrier.

X_____(Please initial)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy for Virginia Heartburn & Hernia Institute. Our Notice of Privacy Practices provides information about how we may use and disclose my protected information. We encourage you to read I in full.

X_____(Please initial)

CONSENT FOR TREATMENT

General consent for treatment. I hereby authorize employees to render medical evaluations and care to the patient indicated below.

1. **E-Prescribing Consent.** The Medicare Modernization Act(MMA) of 2003 listed standards that have to be included in an ePresribe program. By signing this consent form, you are agreeing that this office can request and use your prescription medication history from other healthcare professionals and/or third-party pharmacy benefit payers for treatment purposes.
2. **Patient Information.** I authorize the practice to provide_____
   Print Name/Relationship
   with information (including both medical and billing information). This release will remain active in your electronic health record and will not be cancelled unless there is written authorization from the patient to do so on file.

   X_____(Please initial)

SURGERY CANCELLATION POLICY

Scheduling of your operative requires a coordination effort of multiple departments; beginning with your doctor and including the hospital. Evaluation at the hospital by administrative, nursing, and anesthesia staff is also a time consuming and expensive period. Also, authorization by your insurance carrier must be obtained of your operation.

Cancellation of surgery is sometimes unavoidable due to medical problems or significant conflicts which cannot be avoided. These cancellations, however, can result in unused operative time. Other patients who could have benefited from that operation time cannot do so unless the operative time is available soon enough.

Therefore, a minimum of **72 hours(3 business days)** notification is required for surgery cancellation. This allows the physicians and their staff to make arrangement to the schedule.**if you must cancel your surgery. Please call the office at 703-372-2280.**

Failure to notify us of the cancellation in the required time, will result in a charge of **$500.00**. This charge will be posted to your account.

**Exceptions to this policy will be made only for emergencies and conflicts beyond your control.*

I have read this policy and understand that cancellation of my surgery may result in a fee of **$500.00**

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care, except in the case of an emergency.

_____ _____
Patient Name(Please Print) **Date**

_____ _____
Signature of Patient,Parent or Legal Guardian **Date**

In the event we do contact you, is it suitable to leave a message(s) in the following manner(check all that apply)

☐ on answering machine/voicemail ☐ with an ADULT household member ☐ exclusively with patient

☐ Cell ☐ Home ☐ Work ☐E-Mail