LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

**Digestive Disease Physicians**
**4660 Kenmore Avenue, Ste. #100 & #305 Alexandria, VA 22304**
**Telephone: (703)751-5763 | Fax: (703) 370-8704**
**www.digestivediseasephysicians.com**

## DEMOGRAPHICS

| LAST NAME | | FIRST NAME | MIDDLE INITIAL |
|---|---|---|---|
| SOCIAL SECURITY NUMBER | | SEX MALE FEMALE | 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)* CAN WE LEAVE A MESSAGE? ☐ YES ☐ NO | | WORK PHONE CAN WE LEAVE A MESSAGE? ☐ YES ☐ NO | CELL PHONE CAN WE LEAVE A MESSAGE? ☐ YES ☐ NO |
| RACE *(please circle one)*<br>White Black/African American Asian<br>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>other: ________________________ |
| EMPLOYER | JOB TITLE/STATUS | EMPLOYER ADDRESS | EMAIL ADDRESS |
| PREFERRED PHARMACY | PHARMACY PHONE NUMBER | PRIMARY CARE PHYSICIAN ADDRESS & PHONE NUMBER | |

## EMERGENCY CONTACT INFORMATION

| LAST NAME | FIRST NAME | PHONE ( HOME or WORK or CELL ) | RELATIONSHIP TO PATIENT |
|---|---|---|---|
| | | | |

## INSURANCE POLICY INFORMATION

| NAME OF INSURANCE COMPANY/PLAN | POLICY NUMBER | GROUP NUMBER | EFFECTIVE DATE |
|---|---|---|---|
| TYPE (please circle one only)<br>Health Other _________________ | PRIMARY INSURANCE?<br>Yes No | COPAYMENT AMOUNT<br>Office$_______Specialist:$_______ | DO YOU HAVE MEDICARE A or B<br>YES NO |
| IF POLICY HOLDER IS NOT PATIENT PLEASE PROVIDE THE FOLLOWING: | POLICY HOLDER NAME | | RELATION TO PATIENT |
| SEX (PLEASE CIRCLE ONE) MALE FEMALE<br>STATUS (PLEASE CIRCLE ONE) SINGLE MARRIED<br>WIDOWED DOMESTIC PARTNER | DATE OF BIRTH *(mm/dd/yy)* | | SOCIAL SECURITY NUMBER |
| POLICY HOLDER HOME ADDRESS and PHONE NUMBER | | EMPLOYER and WORK PHONE NUMBER | |

**Please Bring Your Insurance Card & Driver's License & Copay To Every Appointment.**

**PLEASE CONTINUE →**

SECONDARY INSURANCE INFORMATION (if applicable)

<table>
<tr><td colspan="2">NAME OF INSURANCE COMPANY/PLAN</td><td colspan="3">POLICY NUMBER GROUP NUMBER</td><td>EFFECTIVE DATE</td></tr>
<tr><td colspan="2">TYPE (please circle one only)<br>Health Other ________________</td><td>PRIMARY INSURANCE?<br>Yes No</td><td colspan="2">COPAYMENT AMOUNT<br>Office$______Specialist:$______</td><td>DO YOU HAVE MEDICARE A or B<br>YES NO</td></tr>
<tr><td colspan="2">IF POLICY HOLDER IS NOT PATIENT PLEASE PROVIDE THE FOLLOWING:</td><td colspan="4">POLICY HOLDER NAME RELATION TO PATIENT</td></tr>
<tr><td colspan="2">SEX (PLEASE CIRCLE ONE) MALE FEMALE<br>STATUS (PLEASE CIRCLE ONE) SINGLE MARRIED<br>WIDOWED DOMESTIC PARTNER</td><td colspan="3">DATE OF BIRTH (mm/dd/yy)</td><td>SOCIAL SECURITY NUMBER</td></tr>
<tr><td colspan="3">POLICY HOLDER HOME ADDRESS and PHONE NUMBER</td><td colspan="3">EMPLOYER and WORK PHONE NUMBER</td></tr>
</table>

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 services acting for LMG, PC or any of its affiliates.

I agree to promptly pay for services rendered or the patient named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees.

**CANCELLATION POLICY**: IT IS THE OFFICE POLICY TO RENDER CHARGES FOR ANY MISSED APPOINTMENTS OF WHICH I DID NOT PROVIDE PROPER ADVANCED NOTIFICATION. **OFFICE VISITS**: 24 BUSINESS HOURS OR $50 CHARGE. **PROCEDURES:** 48 BUSINESS HOURS OR $250 CHARGE.

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.

_______________________________ _______________________________ _____________

**SIGNATURE** **PRINT NAME** **DATE**

**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 an 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 health care provider will tell you the results 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 an 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**