Potomac Family Practice 46165 Westlake Dr, Ste 120 Potomac Falls, VA 20165 | 224-D Cornwall St, NW, Ste 301 Leesburg, VA 20176

PATIENT INFORMATION

Prefix: Mr./Mrs./ Other **Last Name** **First Name** **Middle Name**

Birth Sex*: ☐ Female ☐ Male **Marital Status*:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other:

Social Security # **Employer Name** **Occupation**

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

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

Mailing Street Address* **Apt#** **City** **State** **Zip Code**

Email address: **Phone number:** ☐ Cell ☐ Home ☐ Work w/ Ext

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

ADDITIONAL INFORMATION*

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

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

Gender Identity: ☐ Male ☐ Female ☐ Female-to-Male (FTM)/ Transgender Male/Trans Man ☐ Male-to-Female (MTF)/ Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female ☐ Choose not to disclose ☐ Other:

Sexual Orientation: ☐ Lesbian, gay/homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Don't Know ☐ Choose not to disclose ☐ Something else, please describe:

Preferred Language other than English*:

PHARMACY INFORMATION*

Pharmacy Name **Address** **Phone Number**

EMERGENCY CONTACT / NEXT OF KIN CONATACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt#** **City** **State** **Zip Code**

Contact Preference Number: ☐ Cell ☐ Home ☐ Work w/ Ext

PARENT / GUARDIAN INFORMATION* - *Required if the patient is under 18 years of age*

Last Name **First Name** **Sex** **Relationship to Patient**

Date of Birth: **Social Security#:** **Contact Preference:** ☐ Cell ☐ Home ☐ Work w/ Ext

Address **Apt#** **City** **State** **Zip Code**

RESPONSIBLE PARTY (GUARANTOR) / POLICYHOLDER INFORMATION

Select all that apply: ☐ Responsible Party ☐ Policyholder for Primary Insurance ☐ Party Policyholder for Secondary Insurance

Last Name **First Name** **Sex** **Marital Status** **Relationship to Patient**

Date of Birth **Social Security#** **Contact Preference:** ☐ Cell ☐ Home ☐ Work w/ Ext

Address **Apt#** **City** **State** **Zip Code**

PRIMARY INSURANCE INFORMATION*

Insurance Name **Member ID/Group#** **Effective Date** **Employer** **Relationship to Policyholder**

SECONDARY INSURANCE INFORMATION*

Insurance Name **Member ID/Group#** **Effective Date** **Employer** **Relationship to Policyholder**

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 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. **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 transit 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 beside 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 external 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 Loudoun Medical Group to:

- Determine the pharmacy benefits and drug 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 for 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 medications prescribed for a patient by any provider.
- Also, this is notice that Loudoun 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 providers 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)