LOUDOUN MEDICAL GROUP

Account Number

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Email:
Street Address		City / State	Zip Code
Home Telephone	Employer Telephone	Cell Telephone	Emergency Telephone/Contact
Social Security Number	**Date of Birth (mm/dd/yy)**	Sex: Male / Female	Single / Married / Divorced / Widowed
Primary Physician (PCP)	Primary Physician (PCP) Phone Number / Address		Pharmacy Name / Phone Number
Patient's Employer	Employer Address		School Name / Phone Number
ETHNICITY (please circle one) Hispanic / Latino Not Hispanic or Latino Unknown	RACE (please circle one) White Black/African American Asian Hawaiian / Other Pacific Islander American Indian / Alaska Native		PREFERRED LANGUAGE English Spanish Or other:

RESPONSIBLE PARTY / BILLING INFORMATION

Last Name (if different from patient)	First Name (if different from patient)	Middle Initial	
Street Address (if different from patient)		City / State	Zip Code
Home Telephone	Cell Telephone	Employer Phone	
Employer	Employer Address		
Social Security Number			

PRIMARY INSURANCE INFORMATION

Name of Company		Office Co-Pay $	Insurance Telephone
ID / Policy Number		**Group Number**	
Insurance Address (if listed on card)		City / State	Zip Code
Insured's Name	Date of Birth	Relationship To Patient	Social Security Number
Insured's Employer	Address / State / Zip Code		Telephone

SECONDARY INSURANCE INFORMATION

Name of Company			Insurance Telephone
Group Number		ID / Policy Number	
Insurance Address (if listed on card)		City / State	Zip Code
Insured's Name	Date of Birth	Relationship To Patient	Social Security Number
Insured's Employer	Address / State / Zip Code		Telephone

PATIENT AUTHORIZATION

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 agree to promptly pay for services rendered for me 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. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I understand that if surgery is warranted, the guidelines set by the hospital and anesthesia departments require patients be seen within 30 days of their surgery date. If surgery is scheduled outside of 30 days from an office appointment, I understand I will be required to return to the office for an additional evaluation. Standard charges and co-payments will apply.

I 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 _____ Date _____