MOUNTAIN VIEW Medical Associates

PATIENT INFORMATION

Personal Information*

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

Previous Name: _____ Preferred Name: _____ Email: _____

Mailing Address*: _____
Street Address Apt. # City State Zip

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

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

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

Referring Provider:_____ Address:_____ Phone #: _____
First Last

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

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

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:_____

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, please specify: _____

Language*: ☐ English ☐ Spanish ☐ Other: _____

Sexual Orientation: ☐ Lesbian, gay/homosexual ☐ Straight/heterosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose ☐ Something else: _____

Pharmacy Name*:_____ Address:_____ Phone #:

Emergency Contact*

Name:_____ Relationship: _____
Last First

Address: _____
Street Address Apt # City State Zip

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

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 #:_____ Relationship to Insured:_____
Employer:_____ Group #:_____ Effective Date: _____
mm/dd/yyyy

Insured's Information* - (if not self)

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

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

Address: _____
Street Address Apt # City State Zip

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

Secondary Insurance Information

Insurance Name:_____ Member ID #:_____ Relationship to Insured:_____

Group#:_____ Effective Date: _____

Secondary Insured's Information - (if not self)

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

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

Address: _____
Street Address Apt # City State Zip

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

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)