



LOUDOUN  
INTERNAL MEDICINE  
ASSOCIATES

44055 Riverside Parkway  
Suite 116  
Leesburg, VA 20176  
Phone: (703) 858-3220  
Fax: (703) 858-3221

921 East Main Street  
Suite D  
Purcellville, VA 20132  
Phone: (703) 858-3204  
Fax: (540) 338-0100

### Our Philosophy

“What a piece of work is man? How noble in reason! How infinite in faculty! In form, in moving, how express and admirable! In action, how like an angel! In apprehension how like a god! ...And yet to me, what is this quintessence of dust?”

-Shakespeare, *Hamlet*

We are at a time of great trial in Medicine and we ask your forbearance for a few minutes as you read this so, if not understanding, the freedom of misunderstanding is the result.

The chief complaints that we hear center on delay and telephones. Our telephone system is one the biggest sources of complaints. “I can’t get through!” I used to be able to talk to a human!”

We rarely hear complaints about care, compassion or competence.

We are totally devoted to the care of that “quintessence of dust” – you, by this “quintessence of dust” – us! What follows are suggestions on how we can help each other in the quest for continued health.

**BACKGROUND:** The last twenty years in Medicine and surgery will be viewed as a revolution for three reasons:

First, the pharmacy of medicine changed radically as we entered the era of designer medication. As we know more about the biochemical workings of the human we are able to produce more precise medications. These medications are no longer “one size fits all.” From hypertension to diabetes to heart disease to psychiatry we now have the reality of precision and effectiveness that is dramatically able to improve your life. This means each suite of pills is individually tailored to your needs. Medicine is running counter to the American culture of discount malls. Everything is tailored. Nothing is off the rack.

Second, the technology of Medicine and Surgery is in a parallel revolution. This is seen most dramatically in imaging technologies. However, the capabilities of the MRI and PET scans are being paralleled in the laboratory with new tests, the operating room with new techniques and the cancer care center with new modalities. This again allows us to be more precise and faster in diagnosis, but it slows us up in the exam room, because we have to select the best options.

Third, as a result of the new capabilities the cost of medicine and surgery has skyrocketed. In attempt to contain that cost, managed care was invented. Unfortunately the administrative cost of managed care is on the shoulders of our staff. It is that load that is breaking us and bearing us down. About 75% of your calls and paper work have nothing to do with illness; they have to do with dealing with the rules of managed care from formularies to referrals.

**WHAT YOU CAN DO:** Just reading this will help. There are three things that will help us be more accessible and responsive to your needs:

First, carry your formulary and manage your medicines ahead of time. We can’t remember how your insurance plan is trying to save money on medications. There are just too many plans and they change their minds all the time. Carry your formulary with you when you come in so we can prescribe the covered and cheapest medications if they are appropriate. Work through your pharmacy or direct mail [pharmacy so they fax us well ahead of time for refills.

Second, know your plan’s benefits and rules for referrals. Our job is not to go around your plan, but to work within your plan. Your job is to be forehanded in your requests for referrals. Your job is to call your plan with questions about their rules, not us. Realize that many plans are not “user friendly.” They hang up on you. They keep you on hold. They treat us the same way. If that happens complain both to your plan and to your Human Relations Manager where you work. In

humility, the plans rarely listen to our complaints, but they listen to yours. In essence, if we screw up let us know. If they screw up, let them know directly.

Third, take care of yourself and help us take care of you. Modern medicine did not help your grandmother live to be 95. It was probably good genes, hard work, common sense and self-reliance. We have many ways to compensate for bad genes. We have little that can do the job in the face of a poor diet, and no exercise.

**CONCLUSION:** There you have it. The revolution in medicine requires us to each you more about how to stay healthy and how to recover your health when you are ill. The revolution in insurance requires you to become more proactive in facilitating your care with in your plans rules. Working together we can make health happen. Mutual responsibility, common sense and mutual courtesy can make our interaction “In action, how like an angel!”



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Dear Patient,

In order to improve our services to you and to ensure that you receive optimal care, in November 2009, our group, Loudoun Internal Medicine Associates/LIMA, LMG Hospitalist program. We want to ensure that our patients are aware of the program's benefits and of our commitment to working closely with you to ensure that you are receiving the best care possible.

Under LMG's program, which follows a trend in modern medical practice, "hospitalists" are physicians who work exclusively at the hospital and provider services around the clock every day of the week. As the practice of medicine is changing and improving rapidly through the introduction of new medical technology, clinical research and new treatments, it is essential that the delivery of these services keep pace, so that patients received direct and immediate benefits. In addition in many cases of hospitalization, time is of the essence in the delivery of best medical care.

While we recognize that physicians who are associates with the hospital are in the best position to provide in-patient care services, we are committed to working with our patients and with hospital physicians to ensure all-around best possible care for our patients.

**As your internists, LIMA physicians are also available around the clock, seven days a week to:**

- **Ensure that hospital physicians can have immediate access to your medical history and condition, including any procedures and existing diagnostic tests;**
- **Help coordinate your care among various specialists and technicians to ensure optimal care; and**
- **Ensure appropriate follow-up after hospitalization.**

Though our Electronic Medical Records (EMR) system, we can access and provide to the hospital information on your health that can be crucial to your care, especially in case of an emergency. Last but not least, **by coordinating your care we can help avoid duplication of tests reducing the discomfort and cost of your hospital admission.**

**We ask that you or a member of your family contact us soon as possible to inform us about your hospital admission,** whether in Loudoun County or elsewhere. Our doctors are available around the clock to work with the hospital staff to ensure you are given the best care and to follow your progress.

We want our patients to be aware of these procedures. We believe this will result in the highest quality of medical care and is in the best interest of our patients.

With our best wishes,

Loudoun Internal Medicine Associates



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### Office Policies

#### Billing

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable co-pay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. If you do not have your insurance information available at the time of your visit, we require that you pay 100% of charges rendered prior to the visit.

If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due over to a collection agency. In addition to the principle balance due, you will also be responsible for any legal or collection agency fees incurred. We do not accept checks.

#### Cancellations

We will attempt to contact you to remind you of your appointment 48 hours prior to your appointment. If you are unable to keep your appointment, we require a 24 hour notice of cancellation. If you fail to show for your appointment or cancel without notifying us 24 hours in advance, we reserve the right to charge you a \$40.00 no show fee.

#### Prescription Refills

We request 72 hours to refill prescriptions from time of request. The best way to request refills is to call your pharmacy two (2) weeks before your medication runs out and your pharmacy will contact Loudoun Internal Medicine Associates.

#### Referrals/Prior Authorizations

Please call your insurance to verify if a referral/prior authorization is needed. Some insurance companies do not require a referral. Please allow at least 72 hours to obtain your referral. Some insurance's can take up to 7 business days to receive approval or denial. We cannot back date referrals and we cannot accommodate same day referrals unless it is a true emergency.

#### Forms/Medical Records

Forms needing to be filled out by a provider (i.e. school physical form, disability paperwork) are subject to a \$10-\$50 form fee which cannot be billed to your insurance company.

#### Divorce

The parent authorizing treatment for a child that is under the age of 18, will be the parent responsible for the charges related to that care including copays/deductibles. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

#### After Hours Care

You can reach the on call physician by calling our practice at (703) 858-3220. The on call physician will advise you where to go based on your medical condition.

#### Emergencies

If you have a life-threatening emergency, please call 911 or go to your nearest emergency room.

*By signing this form, I have agreed to the terms and conditions listed above.*

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Personal Representative

*Thank you for choosing Loudoun Internal Medicine Associates as your primary care provider.*



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[www.loudouninternalmed.com](http://www.loudouninternalmed.com)

**PATIENT INFORMATION**

LAST NAME		FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER		SEX		PREFIX/SUFFIX
DATE OF BIRTH (mm/dd/yy)		STATUS (please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partner		STUDENT (please check one) <input type="checkbox"/> No <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
STREET ADDRESS		CITY/STATE		ZIP CODE
HOME PHONE (include area code)		WORK PHONE		CELL PHONE
RACE (please check one) <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Other Pacific Islander <input type="checkbox"/> Other Race American <input type="checkbox"/> Indian/Alaska Native		ETHNICITY (please check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		PREFERRED LANGUAGE (please check one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS		EMPLOYER PHONE NUMBER
EMAIL ADDRESS				
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS (please check one) <input type="checkbox"/> Text Message <input type="checkbox"/> Email <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone				

**CONTACT/GUARANTOR INFORMATION**

CONTACT (please check at least one) <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Next of Kin <input type="checkbox"/> Insured <input type="checkbox"/> Authorized to Seek Treatment		LAST NAME		FIRST NAME		MIDDLE INITIAL
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	RELATIONSHIP TO PATIENT		SEX	MARITAL STATUS	
HOME ADDRESS		CITY/STATE		ZIP CODE	HOME PHONE	
EMPLOYER		WORK PHONE		JOB TITLE		

**If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.**

CONTACT (please check at least one) <b>Guarantor</b> <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Next of Kin <input type="checkbox"/> Insured <input type="checkbox"/> Authorized to Seek Treatment		LAST NAME		FIRST NAME		MIDDLE INITIAL
SSN (social security number)	DATE OF BIRTH (mm/dd/yy)	RELATIONSHIP TO PATIENT		SEX	MARITAL STATUS	
HOME ADDRESS		CITY/STATE		ZIP CODE	HOME PHONE	
EMPLOYER		WORK PHONE		JOB TITLE		

—————→  
Over

**INSURANCE POLICY INFORMATION**

<b>POLICY NUMBER</b>		<b>GROUP ID</b>		<b>EFFECTIVE DATE</b>	
TYPE (please check only one) <input type="checkbox"/> Health <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp. <input type="checkbox"/> Other		PRIMARY INSURANCE? (please check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	END DATE	COPAYMENT AMOUNT Office: \$ _____ Specialist: \$ _____	
<b>NAME OF INSURANCE COMPANY/PLAN</b>		<b>INSURANCE COMPANY ADDRESS</b>			<b>PHONE NUMBER</b>
INSURED'S NAME		DATE OF BIRTH (mm/dd/yy)		HOME PHONE	
INSURED'S MAILING ADDRESS			<b>PRIMARY CARE PHYSICIAN (PCP) &amp;/OR REFERRING PHYSICIAN</b>		

**SECONDARY INSURANCE INFORMATION (if applicable)**

<b>POLICY NUMBER</b>		<b>GROUP ID</b>		<b>EFFECTIVE DATE</b>	
TYPE (please check only one) <input type="checkbox"/> Health <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp. <input type="checkbox"/> Other		PRIMARY INSURANCE? (please check one) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	END DATE	COPAYMENT AMOUNT Office: \$ _____ Specialist: \$ _____	
<b>NAME OF INSURANCE COMPANY/PLAN</b>		<b>INSURANCE COMPANY ADDRESS</b>			<b>PHONE NUMBER</b>
INSURED'S NAME		DATE OF BIRTH (mm/dd/yy)		HOME PHONE	

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.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**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 any 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 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.
2. 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.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship (if signature is not of Patient)  
Signature of Person Obtaining Consent



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**LOUDOUN MEDICAL GROUP**  
**Receipt of Notice of Privacy Practices Acknowledgement**

\_\_\_\_\_  
Patient's Name

I have received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

\_\_\_\_\_  
Signature

Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

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**FOR OFFICE USE ONLY**

**I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:**

Date	Staff Initials	Reason
		<b>Refused to sign</b> (circle if applicable)  <b>Other:</b>

**LOUDOUN MEDICAL GROUP PC**  
**NOTICE OF PATIENT PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC  
224-D Cornwall St. N.W., Suite 403  
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

**Who Does this Notice Apply to?**

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

**Why Do We Publish this Notice?**

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

**When Is This Notice Effective?**

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from \_\_\_\_\_ until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

**What Information Does this Notice Cover?**

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

**When Can We Use or Disclose Information About You?**

- **Treatment.** We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We

may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.

These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- **Payment.** We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in



connection with payment for your care.

- **Health care operations.** We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- Unless you object, to friends or family members who are involved in your medical care.
- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.
- To health oversight authorities, for regulatory, licensing and other legal

purposes.

- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

#### What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support

the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for LMG;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the

right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.



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Please take a moment to fill out this medical history form so that your practitioner can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_ Pharmacy Address: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_ Pharmacy Fax Number: \_\_\_\_\_

**Allergies: (List all medications, food and environmental)**

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**Medications: (List all current medications including vitamins & supplements)**

<i>Date started</i>	<i>Medication &amp; Dose</i>	<i>Directions</i>	<i>Reason for Taking</i>	<i>Prescribed by</i>

**Past Medical History: (Please check all that apply)**

<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Headache	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes	<input type="checkbox"/> Migraine Headache
<input type="checkbox"/> Asthma	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Alcohol Disorder	<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Esophageal Reflux	<input type="checkbox"/> Hodgkin's Disease	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Concussion	<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Lupus	<input type="checkbox"/> Stroke Syndrome
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Thyroid Disorder

Please list any other past medical history:

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Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Past Surgical History: (Please check all that apply and include the date)**

<i>Surgery</i>	<i>Date</i>	<i>Surgery</i>	<i>Date</i>	<i>Surgery</i>	<i>Date</i>
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Shoulder Surgery	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Hysterectomy		<input type="checkbox"/> Sinus Surgery	
<input type="checkbox"/> Breast Surgery		<input type="checkbox"/> Hip Surgery		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Cataract Surgery		<input type="checkbox"/> Knee Surgery		<input type="checkbox"/> Thyroid Surgery	
<input type="checkbox"/> C-Section		<input type="checkbox"/> Laparoscopy		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Pacemaker Placement		<input type="checkbox"/> Wisdom Teeth	
<input type="checkbox"/> Cosmetic Surgery		<input type="checkbox"/> Prostate Surgery		<input type="checkbox"/> Other: _____	

**Family History: (Please check all that apply)**

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other family medical history:

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**Prevention Information:**

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Do you use seat belts?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a living will?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have smoke detectors in your home?	<input type="checkbox"/>	<input type="checkbox"/>	Do you practice a healthy diet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a loaded firearm in your home? If yes, how is it stored?	<input type="checkbox"/>	<input type="checkbox"/>	Do you keep a gun at home? Is it locked? ___Yes ___No	<input type="checkbox"/>	<input type="checkbox"/>
Do you use sunscreen?	<input type="checkbox"/>	<input type="checkbox"/>			

Please list any vaccine history:

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Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Social/Lifestyle History:**

Marital Status:  Single  Married  Widowed  Divorced  Separated

If married, spouse's name: \_\_\_\_\_

Children(s) names and age(s): \_\_\_\_\_

What is your occupation: \_\_\_\_\_

What are your hobbies: \_\_\_\_\_

Who lives at home with you: \_\_\_\_\_

Where were you born and raised: \_\_\_\_\_

How long have you been in this area: \_\_\_\_\_

Do you drive an automobile: \_\_\_\_\_ Do you ride a motorcycle/bicycle: \_\_\_\_\_

Do you wear a helmet: \_\_\_\_\_

Do you currently smoke or use nicotine products: \_\_\_\_\_ If yes, for how many years: \_\_\_\_\_

Are you a former smoker: \_\_\_\_\_ If yes, when did you quit: \_\_\_\_\_

Cigarettes (# Packs/day): \_\_\_\_\_ Cigars: \_\_\_\_\_ Pipe: \_\_\_\_\_ Chew Tobacco: \_\_\_\_\_

Have you ever used recreational drugs: \_\_\_\_\_ If yes, when was the last time: \_\_\_\_\_

What kind did you use: \_\_\_\_\_

Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products: \_\_\_\_\_

If yes, which ones and how often: \_\_\_\_\_

Do you take something to help you sleep: \_\_\_\_\_ If yes, what and how often: \_\_\_\_\_

Do you restrict your diet in any way: \_\_\_\_\_ If yes, how: \_\_\_\_\_

Do you drink alcohol:  Never  Occasionally  Daily

If yes, how many days per week do you drink alcohol: \_\_\_\_\_

On a typical day when you drink, how many drinks do you have: \_\_\_\_\_

Do you drink caffeine: \_\_\_\_\_ If yes, how much: \_\_\_\_\_

Ever worked with chemicals, paints, asbestos, or any hazardous material?: \_\_\_\_\_

If yes, what kind: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Review of Symptoms:**

**Please check all that apply.**

Male       Female      Medication allergies:  Yes    No

**Please check any symptoms you are experiencing today.**

<b>Systemic Symptoms</b>	<input type="checkbox"/> fatigue <input type="checkbox"/> fever/chills <input type="checkbox"/> weight change
<b>Head Related</b>	<input type="checkbox"/> headache <input type="checkbox"/> facial pain
<b>Eye</b>	<input type="checkbox"/> trouble with vision <input type="checkbox"/> pain <input type="checkbox"/> redness <input type="checkbox"/> light sensitivity
<b>Ear-Nose-Throat-Mouth</b>	<input type="checkbox"/> earache <input type="checkbox"/> pressure <input type="checkbox"/> ringing <input type="checkbox"/> TMJ <input type="checkbox"/> runny nose <input type="checkbox"/> nose bleeds <input type="checkbox"/> post nasal drip <input type="checkbox"/> sneezing <input type="checkbox"/> snoring <input type="checkbox"/> sore throat <input type="checkbox"/> itchy throat <input type="checkbox"/> hoarseness <input type="checkbox"/> mouth sores <input type="checkbox"/> dryness <input type="checkbox"/> trouble swallowing
<b>Neck</b>	<input type="checkbox"/> swollen glands <input type="checkbox"/> pain <input type="checkbox"/> muscle tightness
<b>Respiratory</b>	<input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath
<b>Cardiovascular</b>	<input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> irregular heart rate <input type="checkbox"/> edema <input type="checkbox"/> fast heart rate
<b>Gastrointestinal</b>	<input type="checkbox"/> abdominal pain <input type="checkbox"/> heart burn <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> blood in stool <input type="checkbox"/> change of bowel habits
<b>Urinary</b>	<input type="checkbox"/> pain <input type="checkbox"/> frequency <input type="checkbox"/> blood in urine
<b>Skin</b>	<input type="checkbox"/> rash <input type="checkbox"/> lesions <input type="checkbox"/> abnormal hair loss
<b>Musculoskeletal</b>	<input type="checkbox"/> joint pain <input type="checkbox"/> back pain <input type="checkbox"/> muscle pain <input type="checkbox"/> restless legs
<b>Neurological</b>	<input type="checkbox"/> fainting <input type="checkbox"/> numbness <input type="checkbox"/> dizziness
<b>Psychological</b>	<input type="checkbox"/> insomnia <input type="checkbox"/> depression <input type="checkbox"/> anxious <input type="checkbox"/> irritable <input type="checkbox"/> generally not having fun in life
<b>Male</b>	<input type="checkbox"/> slow urine flow <input type="checkbox"/> low libido <input type="checkbox"/> erectile dysfunction
<b>Female</b>	<input type="checkbox"/> pelvic pain <input type="checkbox"/> PMS <input type="checkbox"/> vaginal discharge <input type="checkbox"/> abnormal bleeding Date of last period: _____ Date of last pap: _____ Period last ____ days   Period comes every ____ days # of pregnancies _____ # of births _____ Current method of birth control _____
<b>Date of last tetanus shot</b>	

Other additional comments:

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