Ashburn Pediatrics

Mailing Address:_____
Street Address City State Zip

Primary Phone # _____ May we leave you a message about results? Yes ☐ No ☐

Patient(s) Last Name	First Name	Date Of Birth	Race/Ethnicity	Sex

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

Primary Care Provider:_____

Additional Information

Email:_____ Language:_____

Preferred Pharmacy:_____
Name Street Address City State Zip

Parent/Guardian Information (1) – Required if patient is under 18 years of age Date of Birth:_____

Name:_____ Occupation:_____
Last First

Address: _____
Street Address City State Zip

Home #:_____ Cell #:_____ Relationship to Patient(s):_____

Parent/Guardian Information(2) – Required if patient is under 18 years of age Date of Birth: _____

Name:_____ Occupation:_____
Last First

Address: _____
Street Address City State Zip

Home #:_____ Cell #:_____ Relationship to Patient(s):_____

Primary Insurance Information

Insurance Name:_____ Member ID #:_____ Social Security #:_____

Employer:_____ Group #:_____ Effective Date:_____

Insured's Information

Name:_____ Sex:_____ DOB:_____

Address: _____
Street Address City State Zip

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)**

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)