Mountcastle
Plastic Surgery & Vein Institute

Name_____ Date of Birth_____

Address_____

Home Phone_____ Cell: _____ Work: _____

Social Security Number_____ Occupation _____

Spouse's Employer_____ Spouse's Phone_____

HEALTH INSURANCE

Primary carrier _____ Insurance ID # _____

Insurance address _____

Policyholders Name/SSN/ DOB if other than patient_____

Secondary carrier _____ ID # _____

Insurance address _____

Emergency Contact _____ Phone Number _____

_____

_____

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 service 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 medial 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 forgery 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 copayments 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 _____

I hereby authorize the release of medical information via fax as may be deemed necessary by my physician, with regard to my medical care.

Signature _____ Date _____

I agree to allow you to speak to the following family members or acquaintances about my medical care. You may correspond with them either in person, via phone, email or mail.

_____

_____

_____

Signature _____ Date _____

Loudoun Medical Group Receipt of Notice of privacy practices acknowledgment:

I, _____, acknowledge receiving on the below date, a copy of Loudoun medical group's notice of privacy practices.

Signature _____ Date _____