Optimum Physical Therapy & Sports Medicine

PATIENT INFORMATION

Personal Information*

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

Previous Name: _____ Preferred Name: _____

Mailing Address*: _____
(Street Address, 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*: _____ 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*

Email: _____

Race*: ☐ Caucasian/White ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: _____

Language*: ☐ English ☐ Spanish ☐ Other: _____

Pharmacy Name*: _____ Address: _____ Phone #: _____
(Street Address, City, State, Zip)

Emergency Contact*

Name: _____ Relationship: _____
(Last, First)

Address: _____
(Street Address, City, State, Zip)

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

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name: _____ Date of Birth: _____ Sex: _____Social Security #: _____ - _____ - _____
(Last, First, mm/dd/yyyy)

Address: _____
(Street Address, 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: _____ Sex: _____ Social Security #: _____ - _____ - _____
(Last, First, mm/dd/yyyy)

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

Address: _____
(Street Address, 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: _____ Sex: _____ Social Security #: _____ - _____ - _____
(Last, First, mm/dd/yyyy)

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

Address: _____
(Street Address, 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)**

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)

*****NOTICE TO AND AGREEMENT BY MEDICARE PATIENTS ONLY-CONTINUE & SIGN BELOW*****

Medicare and your private insurance carrier will only pay for services that it determines to be "reasonable and necessary' under Section 1862(a)(1) of the Medicare Law. During your treatment, we may provide you with useful and beneficial services that Medicare decides are not "reasonable and necessary". You will be responsible for paying charges associated with those services, and by signing this form, you agree to do so. Accordingly, it will be your responsibility to ascertain whether Medicare and your insurance cover any services we provide you.

*****There is a $2080 per calendar year CAP for outpatient therapy for 2020*****

*Patient/Guardian Signature*_____ *Date*_____