THE ORTHOPEDIC GROUP

LEESBURG | LANSDOWNE | STONESPRINGS

PATIENT			
Name (First, Middle, Last)		Date of Birth	Social Security Number
Street Address			Phone # Home
City	State	Zip	Phone # Work
Employer's Name/Address FT PT NOT EMPLOYED		Sex □ Male □ Female □ Other □ Transgendered	Phone # Cell
Language □ English □ Spanish □ Sign Language □ Other:	Race □ American Indian/Alaskan Native □ Asian/Pacific Islander □ Black/AA □Hispanic □ Multiracial □ Refuse to report □White/Caucasian □ Other	Ethnicity □ Not Hispanic or Latino □ Hispanic or Latino □ Refused / Undetermined	Marital Status □ Single □ Married □ Divorced □ Separated □ Widowed

RESPONSIBLE PARTY (If patient is a minor)		
Name (First, Middle, Last)	Date of Birth	Social Security Number
Street Address	Phone #- Home	Phone #- Work
City, State, Zip	Sex □ Male □ Female □ Other □ Transgendered	Relationship to Patient □ Parent □ Guardian □ Other
Custodial Parent	Home Phone	Cell

EMERGENCY CONTACT INFORMATION		
Name	**Phone #**	**Relationship to Patient**

Primary Care Provider full name (PCP) _____ PHONE: _____

REFERRING DOCTOR (if different from PCP): _____ PHONE: _____

IS THIS WORKMANS COMP? (IF YES PLEASE COMPLETE THIS SECTION): _____

WORKERS COMP INFORMATION ONLY:

EMPLOYER: _____ **PHONE#:** _____

BILL TO: _____

CLAIM#: _____ **AUTHORIZED BY:** _____

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
Insurance Carrier Name COPAY	Insurance Carrier Name COPAY
Member/Subscriber ID# Group#	Member/Subscriber ID# Group#
Claim Address	Claim Address
City State Zip	City State Zip
Subscriber (Policy Holder) Name:_____ SSN#:_____ D.O.B:_____/_____/_____ Relationship to Patient: _____ Employer's Name and Address:_____	Subscriber (Policy Holder) Name:_____ SSN#:_____ D.O.B:_____/_____/_____ Relationship to Patient: _____ Employer's Name and Address:_____

Pharmacy Information

Below please list your preferred local pharmacy and mail order pharmacy, if applicable.

Local Pharmacy
Name/Location:_____

Mail Order
Pharmacy:_____

Reminders

As a courtesy to our patients, we will send appointment reminders 1-2 business days before your appointment. Failure to receive a reminder does not relieve you of your responsibility to keep your appointment or cancel it in a timely manner, per our No-Show Policy.

I would like my Office contact/ appointment reminders by <u>PHONE:</u>
□ HOME # □ CELL # □ WORK #

I would like my appointment reminders by <u>TEXT MESSAGE</u>:
Cell # _____

PATIENT
EMAIL:_____
(IF YOU WOULD LIKE TO BE ON THE PATIENT PORTAL PLEASE REQUEST INSTRUCTIONS FROM THE FRONT DESK)

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Patient Consent for Use and Disclosure of Protected Health Information (HIPAA)

I hereby give my consent for The Orthopedic Group, to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). This may include releasing information to specialists for continued treatment. (The notice of Privacy Practices provided by The Orthopedic Group describes such uses and disclosures more completely).

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Orthopedic Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to this office, attention to the Practice Administrator.

By signing this form, I am consenting to allow The Orthopedic Group to use and disclose my PHI to carry out TPO. I understand that this consent also grants permission to The Orthopedic Group to view my prescription history from external sources. I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, The Orthopedic Group may decline to provide treatment to me.

The Orthopedic Group may contact me at my home/work/cell numbers or my home address regarding my diagnosis, results, payment, or treatment and care. I may request any other means of communication or I may deny a particular means of communication in writing.

Signature (seal): _____ Date: _____

LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Patient Name: _____ **Patient DOB:** _____

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.

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

_____
Relationship (if any)

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FINANCIAL AGREEMENT

INSURANCES

All copays, deductibles, or overdue balances are your responsibility and payment is expected at the time of each visit. It is your responsibility to verify that we have your current address, phone number and insurance information on file. If we participate with your insurance company, we will submit all services performed in our office for reimbursement, unless we have received prior notification of non-covered services. If we do not participate with your insurance company, you are responsible for payment in full at the time services are rendered. We do not file claims relating to auto accidents and/or work related conditions. Insurance companies often require pre-authorization as a condition of reimbursement, whether or not we participate with them. It is your responsibility to obtain any required insurance referrals or authorizations prior to your visit and to know your policy's exclusions. You must report all active health insurance payers at each visit. You are required to know the order of which your payers are to be billed. (Primary, Secondary or Tertiary) Failure to report co-ordination of benefits among active health insurance payers will result in your being financially responsible those denials and/or recoupment. You must present your insurance identification card(s) at each visit.

PAYMENT FOR SERVICES

Payment for each visit is expected at the time of service. You will be charged for missed appointments if you fail to provide 24 hours notice. The Orthopedic Group allows one free missed appointment per year. Each No-show/Missed Appointment thereafter is $50.00. You are fully responsible for these charges, as they are not covered by your insurance. Payment in full, of any past due balance, is expected prior to being seen for treatment. You are responsible for balances that result in a denial, regardless of dispute status with the payer. If the insurance company re-adjudicates your claim, you will be granted a refund less the contracted allowable rate stipulated by your insurance.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS/CONSENT TO TREATMENT

I understand that certain information may be required by third party sources for the purpose of treatment, payments to include collections of past due accounts and health care operations. I hereby consent to The Orthopedic Group to release my health information for the purposes of treatment, payment, and healthcare operations. I hereby assign to the practice all benefits/payments for services rendered. I understand that I am responsible for all amounts not covered by my insurance. My signature below acknowledges that I have been provided The Orthopedic Groups notice of privacy practices.

FMLA PAPERWORK/DISABILITY PAPERWORK

The Orthopedic Group does charge $25.00 per packet for any disability or FMLA paperwork. Please note that if you need multiple packets going to different agencies there will be a charge per packet. We appreciate your understanding in this matter as this is very time consuming for our staff.

_____ _____

Signature of Patient or Guardian (SEAL) Date

MATTHEW GAVIN, MD

224-D Cornwall Street, N.W. ▪ Suite 204 ▪ Leesburg, VA ▪ 20176

(703) 777.3262

Review of Systems

Please check any of the following problems that apply to you personally.

GENERAL HEALTH

Good general health lately _____
Recent weight change _____
Fever _____
Fatigue _____
Headaches _____
Loss of appetite _____

EYES

Eye disease or injury _____
Wear glasses / contact lens _____
Blurred or double vision _____
Glaucoma _____

EAR / NOSE / MOUTH / THROAT

Hearing loss or ringing _____
Earaches or drainage _____
Chronic sinus problem or rhinitis _____
Nose bleeds _____
Mouth sores _____
Bleeding gums _____
Bad breath or bad taste _____
Sore throat or difficulty swallowing _____
Swollen glands in neck _____

CARDIOVASCULAR

History of pulmonary embolism _____
Heart trouble _____
Chest pain or angina pectoris _____
Palpation _____
Shortness of breath with walking or lying flat _____
Severe cramping in legs when walking _____
Swelling of feet, ankles or hands _____

RESPIRATORY

Chronic or frequent coughs _____
Spitting up blood _____
Shortness of breath _____
Asthma or wheezing _____

GASTROINTESTINAL

Loss of appetite _____
Change in bowel movements _____
Nausea or vomiting _____
Frequent diarrhea _____
Painful bowel movements or constipation _____
Rectal bleeding or blood in stool _____
Abdominal pain or heartburn _____
Peptic ulcer (stomach or duodenal) _____

GENITOURINARY

Frequent urination _____
Burning or painful urination _____
Blood in urine _____
Change in force or strain when urinating _____
Incontinence or dribbling _____
Kidney stones _____
Sexual difficulty _____
Urinary tract infections _____
Enlarged prostate _____

MUSCULOSKELETAL

Joint pain, stiffness or swelling _____
Shooting leg pain _____
Weakness of muscles or joints _____
Muscle pain or cramps _____
Back pain _____
Cold extremities _____
Difficulties in walking or standing _____
Frequent dislocations _____

SKIN CONDITIONS (skin, breast)

Rash or itching _____
Change in skin color _____
Change in hair or nails _____
Varicose veins _____
Breast pain / lump / discharge _____
Painful bumps on the skin _____

NEUROLOGICAL

Frequent or recurring headaches _____
Nighttime cramps _____
Convulsions or seizures _____
Numbness or tingling sensations _____
Tremors _____
Paralysis _____
Stroke _____
Head injury _____
Claustrophobia _____

PSYCHIATRIC

Memory loss or confusion _____
Nervousness _____
Panic attacks _____
Depression _____
Insomnia _____

ENDOCRINE

Glandular or hormone problem _____
Thyroid disease _____
Diabetes _____
Excessive thirst or urination _____
Heat or cold intolerance _____
Skin becoming dryer _____
Excessive facial hair _____

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts _____
Bleeding or bruising tendency _____
Anemia _____
Phlebitis or Blood clot _____
Past transfusion – blood or platelet _____
Enlarged glands _____

ALLERGIC / IMMUNOLOGIC

History of skin reaction or other adverse reaction _____
Penicillin or other antibiotics _____
Morphine, Demerol or other narcotics _____
Novocaine or other anesthetics _____
Aspirin or other pain remedies _____
Tetanus antitoxin or other serums _____
Iodine, merthiolate or other antiseptics _____

MATTHEW GAVIN, MD
224-D Cornwall Street, N.W. Suite 204 Leesburg, VA 20176
(703) 777-3262

Patient Medical History Form

Last Name:_____ First Name:_____ MI:____ Today's Date:_____

DOB:_____ Age:_____ SSN:_____ Marital Status: S M D W

Height:_____ Weight:_____lbs. Occupation:_____

Have you or anyone in your family seen Dr. Gavin before? Yes / No (If yes, whom? _____

Who referred you?_____

Who is your Primary Care Physician?_____

What are you being seen for?_____ Right / Left / Both

Is this due to injury? Yes / No (If yes, please check one below?
□ Work related from ____/____/_____ □ MVA from____/____/_____ □ Other_____
Date of onset:_____ How did this occur?_____

Do you participate in any sports exercise of any kind? Yes / No (If yes, please explain.)
_____

Do you smoke? Yes / No / Former Alcohol Consumption: Yes / No Recreational Drugs: Yes / No

Pharmacy Name / Location:_____
Allergies: NKDA / Yes _____
_____

LIST ANY CURRENT MEDICAL PROBLEMS:	**SURGERIES:**	**YEAR:**

MEDICATIONS:

NAME:	**DOSE:**	**FREQUENCY:**

PLEASE LIST FAMILY HISTORY HERE:
