



# ENDOCRINE

– Health & Wellness –

Please fill out completely & print clearly.

Full Name:			Date:
First:	Middle:	Last:	
Birthdate:	Age:	Height:	Weight:

Who referred you to our practice? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_

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

Describe your emotional state of well-being: \_\_\_\_\_

Preferred Pharmacy: (Name, City and Phone Number) \_\_\_\_\_

Allergies: Medications, food, environmental	List Reaction:

Medications: (List all current medications)

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

**Past Medical History:** (Please check any past medical history and/or list any past medical history under other)

<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Alcohol Disorder/Drug addiction	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> EKG (list year)	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Reflux
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hodgkin's Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Esophageal Reflux	<input type="checkbox"/> Kidney Dialysis	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Artificial joints	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Kidney poor function	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Blood clots in legs	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Leukemia	<input type="checkbox"/> STDs
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Cancer (list type)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lupus	<input type="checkbox"/> Stroke Syndrome
<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Gout	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Concussion	<input type="checkbox"/> Headache	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Migraine or Headache (circle which one)	<input type="checkbox"/> Ulcer disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Urinary tract infections
<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis or Jaundice (circle which one)	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/>
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Other (List)	

**Please list any surgeries:** (Please write year of surgery and type)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**Family History:** (All medical problems, surgeries, cancer and cause of death)

	Medical Problems	Surgeries	Cancer	Cause of death (age)
Mother:				
Father:				
Grandmother (Maternal)				
Grandfather (Maternal)				
Grandmother: (Paternal)				
Grandfather (Paternal)				
Brother				
Sister				
<b>Other: Please list any significant health issues with Aunts, Uncles, Cousins, and Children</b> <b>Please specify who has the specific issue.</b>				



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**Social History:** (Please write and/or CHECK the appropriate answer)

Who lives with you?	
Occupation:	
Do you currently smoke?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Former
How much per day do you smoke?	_____ Pack per day or _____ cigarettes per day
What do you smoke? (ie cigars)	
Do you drink alcohol?	<input type="radio"/> Yes <input type="radio"/> No
How often do you drink?	<input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Social Drinker
Do you currently use recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
Have you ever used recreational drugs?	<input type="radio"/> Yes <input type="radio"/> No
Please specify type and extent of use:	
Are you pregnant?	<input type="radio"/> Yes <input type="radio"/> No
Date of Last Menstrual cycle?	
Where were you born?	
With who do you live now?	
Children (give sex and age in years)	
Highest education level you completed	<input type="radio"/> GED <input type="radio"/> High school <input type="radio"/> College <input type="radio"/> Graduate School
What are your hobbies, recreation activities?	
Religion (Catholic, Protestant, Jewish, Christian)	

**Health History:** (Please write and/or CHECK the appropriate answer)

Present weight: (In Pounds)	
The most you ever weighted (not pregnant) (in pounds):	
Has your weight changed in the past year?	Gained [ ] pounds Lost [ ] pounds
Reason for weight gain or loss?	
Your height and if you lost height, how much?	
How many hours of exercise or heavy work do you do each week? (Include the type of exercise)	Number of hours:
How healthy are you now?	<input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor
Year of last: (List the year in the blank)	[ <input type="radio"/> ] Tetanus booster [ <input type="radio"/> ] Pneumococcal [ <input type="radio"/> ] Flu [ <input type="radio"/> ] Hep B



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**Women Health History:** (Please write and/or CHECK the appropriate answer)

Number of times you have been pregnant?	
Number of miscarriages or abortions you have had:	
Number of children you delivered:	
Number of living children you have:	
Complications of pregnancy: What was the complication?	
Age periods began:	Years of age:
Had tubes tied?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had a hysterectomy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had ovaries removed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Periods are about every:	[     ] weeks and last about [     ] days
Periods are normally heavy:	<input type="radio"/> Yes <input type="radio"/> No
Bleeding between periods:	<input type="radio"/> Yes <input type="radio"/> No
Had the menopause but am bleeding now	<input type="radio"/> Yes <input type="radio"/> No
Sever cramps with period: What type of medication is used for cramps?	
Repeated episodes of vaginitis	<input type="radio"/> Yes <input type="radio"/> No
Pain with intercourse	<input type="radio"/> Yes <input type="radio"/> No
Contraceptive use, if yes what do you use?	
Year of last Pap smear?	

**Men Health History:** (Please write and/or CHECK the appropriate answer)

Prostate Trouble	<input type="radio"/> Yes <input type="radio"/> No
Burning or discharge from penis	<input type="radio"/> Yes <input type="radio"/> No
Swelling, pain, tenderness, or a lump on testicles:	<input type="radio"/> Yes <input type="radio"/> No
Trouble with erections:	<input type="radio"/> Yes <input type="radio"/> No
Had a vasectomy:	<input type="radio"/> Yes <input type="radio"/> No

**Personal Information\***

**PATIENT INFORMATION**

Prefix: Mr./Mrs./Other: \_\_\_\_\_ Patient Name\*: \_\_\_\_\_ Suffix: Jr./Sr./Other: \_\_\_\_\_  
Last First Middle Initial

Previous Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address\*: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
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\*: \_\_\_\_\_ 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\***

Race\*:  Caucasian/White  Asian  Black/African American  Hawaiian/Pacific Islander  Other: \_\_\_\_\_

Ethnicity\*:  Hispanic/Latino  Non-Hispanic or Latino

Gender Identity:  Male  Female  Female-To-Male (FTM)/Transgender Male/Trans Man  Male-To-Female (MTF)/Transgender  
Female/Trans Woman  Genderqueer, neither exclusively male nor female  Choose not to disclose  Other, please specify: \_\_\_\_\_

Language\*:  English  Spanish  Other: \_\_\_\_\_

Sexual Orientation:  Lesbian, gay/homosexual  Straight/heterosexual  Bisexual  Don't know  Choose not to disclose  
 Something else: \_\_\_\_\_

Pharmacy Name\*: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Emergency Contact\***

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
Street Address Apt # City State Zip

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birth Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First mm/dd/yyyy

Address: \_\_\_\_\_  
Street Address Apt # 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: \_\_\_\_\_ Birth Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First mm/dd/yyyy

Relationship to Insured: \_\_\_\_\_ Marital Status\*:  Single  Married  Widowed  Separated  Divorced

Address: \_\_\_\_\_  
Street Address Apt # 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: \_\_\_\_\_ Birth Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First mm/dd/yyyy

Relationship to Insured: \_\_\_\_\_ Marital Status\*:  Single  Married  Widowed  Separated  Divorced

Address: \_\_\_\_\_  
Street Address Apt # 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 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. X \_\_\_\_\_ (Please initial)

### 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.

### 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)

**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)  <u>Other:</u>

## LOUDOUN MEDICAL GROUP

### NOTICE OF PRIVACY LOUDOUN MEDICAL GROUP

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**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.**

Effective Date: **2/16/2026**

If you have any questions about this notice, please contact the Loudoun Medical Group Privacy Officer at (703) 737-6010.

#### **WHO WILL FOLLOW THIS NOTICE**

This notice describes the Loudoun Medical Groups of:

- Loudoun Medical Group.
- Any health care professional authorized to enter information into your medical record maintained by Loudoun Medical Group.
- Any persons or companies with whom Loudoun Medical Group contracts for services to help operate our Loudoun Medical Group and who have access to your medical information.
- All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or health care operations purposes and other purposes described in this notice.

#### **OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from Loudoun Medical Group. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care and billing for that care that are generated or maintained by Loudoun Medical Group, whether made by Loudoun Medical Group personnel or other health care providers. Other health care providers may have different policies or notices about confidentiality and disclosure that apply to your medical information that is created in their offices or at locations other than Loudoun Medical Group.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy Loudoun Medical Groups at Loudoun Medical Group, and your legal rights, with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

#### **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, volunteers, or other personnel who are involved in taking care of you at Loudoun Medical Group. For example, a doctor treating you for a broken hip may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about you to people outside Loudoun Medical Group who may be involved in your medical care after you have been treated by Loudoun Medical Group, such as friends, family members, or employees or medical staff members of any hospital or skilled nursing facility to which you are transferred or subsequently admitted.
- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from Loudoun Medical Group may be billed by Loudoun Medical Group and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received from Loudoun Medical Group so your health plan will pay us or reimburse you for the treatment. We also may disclose information about you to another health care provider, such as a hospital or skilled nursing facility to which you are admitted, for their payment activities concerning you.

- **For Health Care Operations.** We and our business associates may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Loudoun Medical Group and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Loudoun Medical Group should offer, and what services are not needed. We may also disclose information to doctors, nurses, technicians, and other personnel affiliated with Loudoun Medical Group for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identities of specific patients. We also may disclose information about you to another health care provider for its health care operations purposes if you also have received care from that provider.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend different ways to treat you.
- **Fundraising Activities.** We may use medical information about you to contact you in an effort to raise money for Loudoun Medical Group and its operations. Specifically, we may use information about you to target our fundraising efforts. For example, if we are raising money for women's health services, we may focus our fundraising efforts on individuals who have received women's health services from us in the past. We may also disclose medical information to a business partner or a foundation related to Loudoun Medical Group so that the business partner or the foundation may contact you in raising money for Loudoun Medical Group. We would release limited information about you, such as your name, address and phone number, age and date of birth, gender, your physician, and the dates you received treatment or services at Loudoun Medical Group.

If you do not want Loudoun Medical Group to contact you for fundraising efforts, you must notify Loudoun Medical Group's Privacy Officer in writing. If you have not already done so, we must ask you each time we contact you for fundraising efforts if you wish to opt out of all future fundraising communications. If you do opt out of future fundraising communications, we will no longer disclose your information for fundraising purposes. However, in the future you may let us know in writing that you would like to receive these fundraising communications. Your decision whether or not to receive targeted fundraising materials from us will have no impact on your access to health care services or the treatment we provide to you.

Even if you have opted-out, we may send you non-targeted fundraising materials that are sent out to the general community and are not based on information from your treatment.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. Medical information about you that has had identifying information removed may be used for research without your consent. We also may disclose medical information about you to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs), so long as the medical information they review does not leave Loudoun Medical Group. If the researcher will have information about your mental health treatment that reveals who you are, we will seek your consent before disclosing that information to the researcher. Unless we notify you in advance and you give us written permission, we will not receive any money or other thing of value in connection for using or disclosing your medical information for research purposes except for money to cover the costs of preparing and sending the medical information to the researcher.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.
- **As Required or Permitted By Law.** We may disclose medical information about you when required or permitted to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when it appears necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

## **SPECIAL SITUATIONS**

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Active Duty Military Personnel and Veterans.** If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.
- **Workers' Compensation.** In accordance with state law, we may release without your consent medical information about your treatment for a work-related injury or illness or for which you claim workers' compensation to your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose without your consent medical information about you for public health activities. These activities generally include but are not limited to the following:
  - To report, prevent or control disease, injury, or disability;
  - To report births and deaths;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - To report suspected abuse or neglect as required by law.
- **Health Oversight Activities.** We may disclose without your consent medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a court or administrative order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a civil dispute.
- **Law Enforcement.** We may release without your consent medical information to a law enforcement official:
  - In response to a court order, warrant, summons, grand jury demand, or similar process;
  - To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings;
  - In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person;
  - To report a death or injury we believe may be the result of criminal conduct; and
  - To report suspected criminal conduct committed at Loudoun Medical Group facilities.
- **Coroners and Medical Examiners.** We may release without your consent medical information to a coroner or medical examiner. This may be done, for example, to identify a deceased person or determine the cause of death. We also may release medical information about deceased patients of Loudoun Medical Group to funeral directors to carry out their duties.
- **National Security and Intelligence Activities.** We may release without your consent medical information about you as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
- **Psychotherapy Notes.** Regardless of the other parts of this Notice, psychotherapy notes will not be disclosed outside the Loudoun Medical Group except as authorized by you in writing or pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within Loudoun Medical Group, except for training purposes or to defend a legal action brought against Loudoun Medical Group, unless you have properly authorized such disclosure in writing.
- **Substance Use Disorder Treatment Information.** If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") based upon a general consent you provide to the Part 2 Program to use and disclose your Part 2 Program record for purposes of treatment, payment, or health care operations, we may use and disclose your Part 2 Program record for treatment, payment, and health care operations purposes as described in this notice. If we are a Part 2 Program and create a Part 2 Program record for you, or if we receive or maintain your Part 2 Program record based upon a specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

- **Marketing of Health-Related Products and Services.** "Marketing" means a communication for which we receive any sort of payment from a third party that encourages you to use a service or buy a product. Before we may use or disclose your medical information to market a health-related product or service to you, we must obtain your written authorization to do so. The authorization form will let you know that we have been paid to make the communication to you. Marketing does not include: prescription refill reminders or other information that describes a drug you currently are being prescribed, so long as any payment we receive for that communication is to cover the cost of making the communication; face-to-face

communications; or gifts of nominal value, such as pens or key chains stamped with our name or the name of a health care product manufacturer. Communications made about your treatment, such as when your physician refers you to another health care provider, generally are not marketing.

- **Sale of Medical Information.** We cannot sell your medical information without first receiving your authorization in writing. Any authorization form you sign agreeing to the sale of your medical information must state that we will receive payment of some kind disclosing your information. However, because a “sale” has a specific definition under the law, it does not include all situations in which payment of some kind is received for the disclosure. For example, a disclosure for which we charge a fee to cover the cost to prepare and transmit the information does not qualify as a “sale” of your information.
- **Inmates.** If you are an inmate of a correctional institution or in the custody of law enforcement, we may release medical information about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to Loudoun Medical Group that such medical information is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the North Carolina Department of Corrections (“DOC”) and the DOC requests your medical records, we are required to provide the DOC with access to your records.

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and receive a copy of your medical record unless your attending physician determines that information in that record, if disclosed to you, would be harmful to your mental or physical health. If we deny your request to inspect and receive a copy of your medical information on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by Loudoun Medical Group will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides.

If we have all or any portion of your medical information in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

Your medical information is contained in records that are the property of Loudoun Medical Group. To inspect or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Loudoun Medical Group’s Privacy Officer. If you request a copy of the information, **we may charge a fee** for the costs of copying, mailing, or other supplies associated with your request, and we may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation.

- **Right to Amend.** If you feel that medical information we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Loudoun Medical Group.

To request an amendment, make your request in writing to Loudoun Medical Group’s Privacy Officer. 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 Loudoun Medical Group;
- Is not part of the information that you would be permitted to inspect and copy; or
- Has been determined to be accurate and complete.

If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your medical record.

- **Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we have made of medical information about you during the past six years.

To request this list or accounting of disclosures, submit your request in writing to Loudoun Medical Group’s Privacy Officer and state whether you want the list on paper or electronically. Your request must state a time period that may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.

- **Right to Request Restrictions.** Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could revoke any and all authorizations you previously gave us relating to disclosure of your medical information.

**We are not required to agree to your request**, with the exception of restrictions on disclosures to your health plan, as described below. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions, make your request in writing to Loudoun Medical Group's Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You may request that we not disclose your medical information to your health insurance plan for some or all of the services you receive during a visit to any Loudoun Medical Group location. If you pay the charges for those services you do not want disclosed **in full at the time of such service**, we are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.

- **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, or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to the Privacy Officer and 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 or any revised 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.

To obtain a paper copy of this notice, request a copy from Loudoun Medical Group's Privacy Officer in writing.

### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Loudoun Medical Group's office. The notice will contain the effective date on the first page, in the top right-hand corner. If the notice changes, a copy will be available to you upon request.

### **INVESTIGATIONS OF BREACHES OF PRIVACY**

We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with Loudoun Medical Group or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Loudoun Medical Group, contact Clara Nussbaum, Loudoun Medical Group's Privacy Officer by mail at 224-D Cornwall Street, NW, Suite 403, Leesburg, VA 20176. All complaints must be submitted in writing.

***You will not be penalized for filing a complaint.***

### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice may be made only with your written authorization or as required by law. If you authorize us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. Your revocation will be effective as of the end of the day on which you provide it in writing to Loudoun Medical Group's Privacy Officer. If you revoke your permission, we will no longer use or disclose medical information about you for the purposes that you previously had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



**AUTHORIZATION TO DISCLOSE INFORMATION**

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

SS# \_\_\_\_\_

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

**INSTRUCTIONS FOR LEAVING MESSAGES  
AND/OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION**

OK to communicate with spouse?  YES  NO

Spouses Name \_\_\_\_\_

OK to leave information on answering machine?  YES  NO

OK to communicate with parent/children?  YES  NO

Name(s) \_\_\_\_\_

OK to communicate with caregiver?  YES  NO

Name \_\_\_\_\_

OK to communicate with any other person(s)  YES  NO

Please list \_\_\_\_\_

Communicate only with me  YES  NO

**THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED IN WRITING**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Other Comments

## PATIENT ACKNOWLEDGEMENT OF OFFICE POLICIES

Endocrine Health and Wellness will file your claim with your insurance if we participate with your insurance plan; otherwise, payment is required in full for all services at the time they are rendered. Should any services not be covered by your insurance, you agree to accept financial responsibility for said services. All applicable co-payments, co-insurance, deductibles and balance owed on your account are to be paid in full and collected at each visit.

Patient statements will be mailed to you every fifteen days. If you have not paid your balance by the tenth day after the third statement is due, your account will be placed with our collection agency. If your unpaid balance is \$300 or above, we will have to postpone any follow-up appointments until the balance has been paid in full.

Forms/Letters required from provider: There is a \$50 charge for each set of disability, ADA, and FMLA forms. There is a \$75 charge for special accommodations forms/letters and insurance appeals. If revisions are needed, then \$25 will be assessed for each revision.

### Referral Information

If a referral is required by your health insurance plan, it is your responsibility to obtain the referral from your Primary Care Physician prior to your visit and keep track of the expiration date of your referral.

### Insurance Cards and Photo Identification

All patients are required to provide a valid insurance card(s) at the time of your visit. All patients are also required to provide photo identification. You are responsible for notifying our office of any changes to your insurance or contact information.

### Photography/Videotaping/Recording

All patients and visitors must respect the privacy of staff members, other patients, visitors, and physicians. Patients/visitors may not photograph, videotape, record or depict in any manner any staff member, other patient, visitor, or physician.

### Dismissal Policy

If you choose to leave and obtain care with another endocrinologist, you will not be accepted back to our practice in the future.

Virginia Law (Section 32.1-45.1 et.cet.)

I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the health care provider, it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia Law (Section 32.1 45.1 et. seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider. I also understand that health providers are deemed to consent to tests and the release of the results to me, should I be similarly exposed.

### HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Endocrine Health and Wellness from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information.

Name Of Individual / Relationship To Patient


May we release your private health information to you via:

\_\_\_\_\_ Email (Please Write Email)

\_\_\_\_\_ Voice Mail At Home

\_\_\_\_\_ Voice Mail On Cell Phone

\_\_\_\_\_ Text Message via Doximity, a HIPAA compliant platform

## PATIENT ACKNOWLEDGEMENT OF CANCELLATION/NO SHOW POLICY

We require 48 business hours notice in the event you need to reschedule or cancel your appointment. If you contact us less than 48 hours before your appointment to reschedule, a \$50 late-cancellation fee will be assessed. A second occurrence will incur a \$75 fee. A third occurrence will incur a \$100 fee. A fourth occurrence will result in dismissal from Endocrine Health and Wellness.

If you are a No Show for your appointment, you will be charged a \$50 fee to reschedule your appointment. A second No Show will incur a \$100 fee to reschedule, and a third No Show will result in dismissal from Endocrine Health & Wellness.

If you are late for an appointment, we will make every effort to ensure that you are seen as soon as possible, however the office visit may need to be shortened in length or rescheduled.

Any new patient who fails to show for their initial visit will only be rescheduled at the discretion of Endocrine Health & Wellness, after a no-show fee of \$100 is paid.

It is the responsibility of each patient to remember their scheduled appointments. No-show/late cancellation fees will be billed to you directly and are not covered by your insurance. Balances are due at each scheduled appointment.

Abusive behavior towards any provider or staff member is not tolerated and is grounds for immediate dismissal from the practice.

**Your signature below signifies your understanding and willingness to comply with all the above policies.**

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Signature

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Date