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**

ENDOCRINE
– Health & Wellness –

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

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

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

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

ENDOCRINE
– Health & Wellness –

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				
Other: Please list any significant health issues with Aunts, Uncles, Cousins, and Children Please specify who has the specific issue.				

ENDOCRINE
— Health & Wellness —

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

Who lives with you?	
Occupation:	
Do you currently smoke?	◯ Yes ◯ No 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?	◯ Yes ◯ No
How often do you drink?	◯ Daily ◯ Weekly ◯ Monthly ◯ Social Drinker
Do you currently use recreational drugs?	◯ Yes ◯ No
Have you ever used recreational drugs?	◯ Yes ◯ No
Please specify type and extent of use:	
Are you pregnant?	◯ Yes ◯ 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	◯ GED ◯ High school ◯ College ◯ 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?	◯ Good ◯ Fair ◯ Poor
Year of last: (List the year in the blank)	[◯] Tetanus booster [◯] Pneumococcal [◯] Flu [◯] Hep B

ENDOCRINE
– Health & Wellness –

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?	**[ ] Yes [ ] No**
Had a hysterectomy?	**[ ] Yes [ ] No**
Had ovaries removed	**[ ] Yes [ ] No**
Periods are about every:	**[ ] weeks and last about [ ] days**
Periods are normally heavy:	**Yes No**
Bleeding between periods:	**Yes No**
Had the menopause but am bleeding now	**Yes No**
Sever cramps with period: What type of medication is used for cramps?	
Repeated episodes of vaginitis	**Yes No**
Pain with intercourse	**Yes 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	**[ ] Yes [ ] No**
Burning or discharge from penis	**[ ] Yes [ ] No**
Swelling, pain, tenderness, or a lump on testicles:	**[ ] Yes [ ] No**
Trouble with erections:	**[ ] Yes [ ] No**
Had a vasectomy:	**[ ] Yes [ ] 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*: _____
Street Address Apt. # 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*:_____ 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 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)**

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)

LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

ENDOCRINE
— Health & Wellness —

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

_____
Patient's Name

I have a 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)

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
		Refused to sign (circle if applicable) **Other:**

LOUDOUN MEDICAL GROUP PC
NOTICE OF PATIENT PRIVACY PRACTICES

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.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from _____ until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment.*** We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment.*** We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in

connection with payment for your care.

- ***Health care operations.*** We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- Unless you object, to friends or family members who are involved in your medical care.
- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appoint-ments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. 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 LMG;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- 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.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must 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. 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.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.

ENDOCRINE
— Health & Wellness —

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

ENDOCRINE
– Health & Wellness –

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.

_____ _____

Signature Date