/etropolita & FACIAL PLASTIC SURGER 6355 Walker Lane-Suite 308 Alexandria, VA 22310 PH: 703-313-7700

FAX: 703-313-0178

PATIENT DEMOGRAPHICS

FIRST NAME:		CELL PHONE (include area code):
MI:LAST	Г NAME:	PCP &/or REFER PHYSICIAN:
PRFX/SUFFIX:	SSN:	PREFERRED LANGUAGE:
DOB:	SEX:	STUDENT: Full Time Part Time Not Enrolled
		ΜΑΡΙΤΑΙ ΟΤΑΤΙΟ.
		PACE:
APT/UNIT # : CITY/STATE:		FTHNICITY
		CONTACT PREFERENCE:
		EMPLOYER:
	de area code):	JOB STATUS Full Time Part Time Retired None
PHARMACY NAME:		PHARMACY PHONE NUMBER:
authorization will allow	my physicians to check drug to drug	y medical history from Pharmacies and/or Pharmacy Benefit Managers. This g interactions for any new prescriptions he/she may prescribe and to facilitate electronic remain in effect until revoked by me in writing. INITIALS: DATE:

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT: _____

RELATION: _____ PHONE: _____

CONSENT TO SHARE INFORMATION

Metropolitan ENT is authorized to release protected health information about the above-named patient to the entities named below:

NAME:	RELATION	PHONE:	
NAME:	RELATION	PHONE:	

(Patient information: I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state laws.)

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL IT IS REVOKED BY THE PATIENT IN WRITING. INITIALS: _____ DATE: _____

METROPOLITAN & FACIAL PLASTIC SURGERY 6355 Walker Lane-Suite 308 Alexandria, VA 22310 PH: 703-313-7700 FAX: 703-313-0178

INSURANCE POLICY INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
NAME OF INSURANCE CO:	NAME OF INSURANCE CO:
NAME OF INSURANCE CO:	NAME OF INSURANCE CO:
	POLICY NUMBER:
	GROUP ID:
EFFECTIVE DATE:	EFFECTIVE DATE:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
RELATION TO SUBSCRIBER:	RELATION TO SUBSCRIBER:
SUBSCRIBER DOB:	SUBSCRIBER DOB:
SUBSCRIBER SSN:	SUBSCRIBER SSN:
SUBSCRIBER ADDRESS:	SUBSCRIBER ADDRESS:

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.

Print Name

Date

Signature

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:

- 1. If any LMG health care professional, worker or employee should be directly exposed to your blood or 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 health care provider will tell you the result of the test. Under Virginia Code § 32.1-45.1 (A), you are deemed to have consented to the release of the test results to the person exposed.
- If you should be directly exposed to blood or body fluid of an LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with the human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or health care provider will tell you and that person the results of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it in writing.

Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parents

Date

Relationship (if signature is not of Patient) Signature of Person Obtaining Consent

LIST ALL MEDICATIONS YOU ARE TAKING

Today's Date: _____

(Prescription, over-the-counter, herbal)

			Dosage	How often]	Reason	
DRUG/NON-DRUG Medication Name or N				Type of Reaction			
Have you ever had S	urgery	or Hos	pitalization?	YES 2/year:			
Have you ever had p				 Yes			
nave you ever nau a	seriou	s injury] YES e of injury/date:			
If female, are you pro	egnant	?	If yes list type	e of injury/date:			
Have you ever had a If female, are you pro <u>MEDICAL HISTOR</u>	egnant	?	If yes list type	e of injury/date:			
If female, are you pro MEDICAL HISTOR	egnant <u>Y</u> : Ha	? 🛛 ve YOU	If yes list type NO 	e of injury/date:	heck <u>all</u>	that app	ply)
If female, are you pro <u>MEDICAL HISTOR</u> Alcoholism	egnant <u>Y</u> : Ha <u>No</u> □	? ve YOU <u>Yes</u> □	If yes list type NO 	e of injury/date:	heck <u>all</u> <u>No</u>	that app <u>Yes</u>	ply)
If female, are you pro MEDICAL HISTOR Alcoholism Anemia	egnant <u>Y</u> : Ha <u>No</u> □	? □ ve YOU <u>Yes</u> □	If yes list type NO 	e of injury/date: een diagnosed with? (cu Glaucoma	heck <u>all</u> <u>No</u> □	that app <u>Yes</u>	ply)
If female, are you pro MEDICAL HISTOR Alcoholism Anemia Angina/Heart Attack	egnant <u>Y</u> : Ha <u>No</u> □ □	? ve YOU <u>Yes</u>	If yes list type NO 	e of injury/date: een diagnosed with? (ca Glaucoma Headache (Type?)	heck <u>all</u> <u>No</u> □	that app <u>Yes</u> □	ply)
If female, are you pro <u>MEDICAL HISTOR</u> Alcoholism Anemia Angina/Heart Attack Arthritis	egnant <u>Y</u> : Ha <u>No</u> □ □	? ve YOU <u>Yes</u>	If yes list type NO 	e of injury/date: een diagnosed with? (c. Glaucoma Headache (Type?) HIV/AIDS	heck <u>all</u> <u>No</u> [] []	that app <u>Yes</u>	ply)
If female, are you pro MEDICAL HISTOR Alcoholism Anemia Angina/Heart Attack Arthritis Asthma	egnant <u>Y</u> : Ha □ □ □	? ve YOU Yes	If yes list type NO 	e of injury/date: een diagnosed with? (cu Glaucoma Headache (Type?) HIV/AIDS High Blood Pressure	heck <u>all</u> <u>No</u> [] [] []	that app <u>Yes</u>	ply)
If female, are you pro <u>MEDICAL HISTOR</u> Alcoholism Anemia Angina/Heart Attack Arthritis	egnant <u>Y</u> : Ha <u>No</u> □ □	? ve YOU <u>Yes</u>	If yes list type NO 	e of injury/date: een diagnosed with? (cd Glaucoma Headache (Type?) HIV/AIDS High Blood Pressure Kidney Disease	heck <u>all</u>	that app <u>Yes</u>	ply)
If female, are you pro MEDICAL HISTOR Alcoholism Anemia Angina/Heart Attack Arthritis Asthma Birth Defect	egnant <u>Y</u> : Ha <u>No</u>	? ve YOU <u>Yes</u>	If yes list type NO 	e of injury/date: een diagnosed with? (ca Glaucoma Headache (Type?) HIV/AIDS High Blood Pressure Kidney Disease Liver Condition	heck <u>all</u>	that app Yes	ply)
If female, are you pro MEDICAL HISTOR Alcoholism Anemia Angina/Heart Attack Arthritis Asthma Birth Defect Bladder Disease	egnant <u>Y</u> : Ha <u>No</u>	? □ ve YOU <u>Yes</u> □ □ □ □ □ □ □ □ □ □ □ □ □	If yes list type NO 	e of injury/date: een diagnosed with? (c. Glaucoma Headache (Type?) HIV/AIDS High Blood Pressure Kidney Disease Liver Condition Lung Condition	heck <u>all</u>	that app <u>Yes</u>	ply)
If female, are you pro MEDICAL HISTOR Alcoholism Anemia Angina/Heart Attack Arthritis Asthma Birth Defect Bladder Disease Bleeding Disorder	egnant <u>Y</u> : Ha	? ve YOU Yes	If yes list type NO 	e of injury/date: een diagnosed with? (ca Glaucoma Headache (Type?) HIV/AIDS High Blood Pressure Kidney Disease Liver Condition Lung Condition Mental Illness	heck <u>all</u>	that app <u>Yes</u>	ply)
If female, are you pro MEDICAL HISTOR Alcoholism Anemia Angina/Heart Attack Arthritis Asthma Birth Defect Bladder Disease Bleeding Disorder Cancer (Type?)	egnant <u>Y</u> : Ha <u>No</u>	? ve YOU Yes	If yes list type NO 	e of injury/date: een diagnosed with? (ca Glaucoma Headache (Type?) HIV/AIDS High Blood Pressure Kidney Disease Liver Condition Lung Condition Mental Illness Stroke	heck <u>all</u>	that app <u>Yes</u>	ply)

Print Name: _____

DOB: _____

SOCIAL HISTORY

No longr Cigartiss Do you consume alcoho? Ber	Do you use Tobacco? 🗆 Yes 🗆 No	□ Former		
	N	√o longerCigarettesPipe _	Cigars	
	Do you consume alcohol? □ Yes □	No 🗖 Former		
bo you use drugs recreationally? Use No CocurineHeroinMarijuanaOxycodomeOther bo you use caffeine? I per day2-3 per day4 or more per day bo you ave caffeine? I per day2-3 per day4 or more per day bo you exercise regularly? I Yes bo you consider yourself generally: I Healthy			iquor	
			iquoi	
Do you use caffeine?	Do you use drugs recreationally?	fes 🗆 No 🗀 Former		
	Co	ocaineHeroinMarijuana	OxycodoneOther	
	Do vou use caffeine? 🗆 Ves 🗆 No			
Do you have pets in the home? Uss No CalDegOther Do you exercise regularly? Vss No TypeOther Do you consider solut to be:No Type Patient considers diet to be:HealthyNot HealthyNot Healthy	-			
	1	per day2-3 per day4 or mo	bre per day	
Do you exercise regularly? Yes No Type Home Living Situation: Alone w/Spouse & Children w/Parents Other	Do you have pets in the home?	□ No		
Do you exercise regularly? Yes No Type Home Living Situation: Alone w/Spouse & Children w/Parents Other	Ca	t Dog	Other	
Home Living Situation: Alone w/Spouse w/Spouse & Children w/Children w/Parents Other Patient considers diet to be: Healthy Other Masee Not Healthy Other Patient consider yourself generally: Healthy Fair Not Healthy Masee Masee Other Drainage Ringing in ears Urination at night Other Diration at night Other Drainage Sensitivity to light Dother Dother Diration at night Other Nose & Sinus Urination at night Other Dother Dother Dother Drainage Sensezing Burred vision Sensitivity to light Dother Drainage Sonoring Bruises easily Moles that have changee Drainage Sonoring Bruises easily Other Hoarseness Hives Infegunentary (Skin) Inflammation of Throat Storing Blood in stool Other Sore throat Other Blood in stool Other Blood in stool Other <th></th> <th></th> <th></th> <th></th>				
Patient considers diet to be: Healthy Other: Do you consider yourself generally: Healthy FartENT REVIEW OF SYSTEMS: Consection Ringing in ears Cenitourinary Drainage Ringing in ears Other Cenitourinary Drainage Ringing in ears Other Cenitourinary Drainage Ringing in ears Other Cenitourinary Drainage Sonoring Blurred vision Cenitourinary Hearing loss Congestion Runny nose Blurred vision Consention Drainage Sneezing Integumentary (Skin) Other Integumentary (Skin) Nosebleeds Other Bruises casily Moles that have changed Drainage Snoring Bruises casily Moles that have changed Inflammation of Throat Snoring Bruises casily Moles that have changed Sore torage Other Respiratory (Lungs and Respiratory System) Cough, non-productive Pain/ightness in chest Sore torage Other Sore intorat Mouth breathing Cough, non-productive Pain/ightness in chest Drak circles under eyes	Do you excreise regularity. 🗋 res			
Patient considers diet to be: Healthy Other: Do you consider yourself generally: Healthy FartENT REVIEW OF SYSTEMS: Consection Ringing in ears Cenitourinary Drainage Ringing in ears Other Cenitourinary Drainage Ringing in ears Other Cenitourinary Drainage Ringing in ears Other Cenitourinary Drainage Sonoring Blurred vision Cenitourinary Hearing loss Congestion Runny nose Blurred vision Consention Drainage Sneezing Integumentary (Skin) Other Integumentary (Skin) Nosebleeds Other Bruises casily Moles that have changed Drainage Snoring Bruises casily Moles that have changed Inflammation of Throat Snoring Bruises casily Moles that have changed Sore torage Other Respiratory (Lungs and Respiratory System) Cough, non-productive Pain/ightness in chest Sore torage Other Sore intorat Mouth breathing Cough, non-productive Pain/ightness in chest Drak circles under eyes	Home Living Situation . D Alone	\square w/Spouse \square w/Spouse & Child	ren □w/Children □w/Pare	ents 🗌 Other
Dy ouy consider yourself generally:				
DATIENT REVIEW OF SYSTEMS: (check all that apply to today's visit) Ears Cenitourinary Drainage Ringing in ears 0 Utin 0 Utination at night 0 Uther	Patient considers diet to be: □ Healt	hy □ Not Healthy □ Other:		
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□ Drainage □ Ringing in ears □ Dizziness □ Other	<u>P</u> A	ATIENT REVIEW OF SYSTEM	$[\underline{S}:$ (check all that apply to today's visit	()
□ Drainage □ Ringing in ears □ Dizziness □ Other	T			_
□ Dizziness □ Other				
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□ Congestion □ Runny nose □ Drainage □ Sneezing □ Itchy nose □ Snoring □ Nosebleeds □ Other □ Hoarseness □ Hives □ Inflammation of Throat □ Snoring □ Sore tongue □ Voice change □ Sore tongue □ Number □ Popping sound in mouth or ear (TMJ) ■ Allergic, Infections, Immune System □ Dark circles under eyes □ Itchy Nose ■ Blacking Out □ Blacking Out □ Chest pain □ Chest pain □ Thematologic □ Masses □ Masses □ Masses □ Masses □ Masses <th></th> <th></th> <th></th> <th></th>				
□ Nosebleeds □ Other □ Infarmation of Throat □ Snoring □ Inflammation of Throat □ Ulcers □ Sore throat □ Ulcers □ Sore tongue □ Voice change □ Sore tongue □ Voice change □ Sore sin Mouth □ Other □ Swallowing difficulty □ Cough, non-productive □ Popping sound in mouth or ear (TMJ) □ Cough, non-productive □ Allergic, Infections, Immune System □ Sleep disturbance due to breathing □ Dark circles under eyes □ Infections (recurring) □ Food intolerance □ Mouth breathing □ Hives □ Other □ Itchy Nose □ Other Cardiovascular (Heart and Blood Vessels) □ Blacking Out □ Swelling □ Irregular heartbeat □ Other Hematologic □ Neurological (Nerves) □ Masses □ Other Masses □ Other	Congestion	Runny nose		
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□ Inflammation of Throat □ Shoring □ Sore throat □ Ulcers □ Sore throat □ Ulcers □ Sore tongue □ Voice change □ Sores in Mouth □ Other □ Swallowing difficulty □ Other □ Popping sound in mouth or ear (TMJ) □ Cough, non-productive ■ Abdominal pain □ Diarrhea □ Sores in Mouth □ Other □ Popping sound in mouth or ear (TMJ) □ Cough, non-productive ■ Dark circles under eyes □ Infections (recurring) □ Dark circles under eyes □ Infections (recurring) □ Food intolerance □ Mouth breathing □ Hives □ Other □ Itchy Nose ■ Swelling □ Chest pain □ Other □ Irregular heartbeat □ Other ■ Masses □ Other ■ Masses □ Other	Throat & Mo	outh	-	
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□ Sore throat □ Ulcers □ Sore tongue □ Voice change □ Sore sin Mouth □ Other □ Swallowing difficulty □ Other □ Swallowing difficulty □ Cough, non-productive □ Popping sound in mouth or ear (TMJ) □ Cough, productive ■ Allergic, Infections, Immune System □ Cough, groductive □ Dark circles under eyes □ Infections (recurring) □ Food intolerance □ Mouth breathing □ Hives □ Other □ Itchv Nose ■ Other ■ Blacking Out □ Swelling □ Chest pain □ Other □ Irregular heartbeat □ Other ■ Masses □ Other			Abdominal pain	🗆 Diarrhea
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Cardiovascular (Heart and Blood Vessels) □ Depression □ Other □ Blacking Out □ Swelling □ Feels sad more than usual □ Chest pain □ Other □ Feels sad more than usual □ Irregular heartbeat □ Appetite is increased □ Neck has enlarged □ Masses □ Other □ Musculoskeletal				
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□ Irregular heartbeat □ Appetite is increased □ Neck has enlarged □ Fatigue □ Other Musculoskeletal				Juai
Hematologic Image: The form of the f			Endo	crine
□ Masses □ Other Musculoskeletal	i irregular neartbeat			
Masses Other Musculoskeletal	Hematolog	गंद	Fatigue	□ Other
WIUSCHIOSKEIC				
\Box Loss of muscle strength \Box Other		· · ·		
			□ Loss of muscle strengt	n 🗆 Otner



6355 Walker Lane-Suite 308 Alexandria, VA 22310 PH: 703-313-7700 FAX: 703-313-0178

Office Policies

Financial Responsibility

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account. We ask that you remit any applicable co-pay, deductible, and co-insurance according to the terms of your insurance contract at the time services are rendered. If you do not have your insurance information available at the time of your visit, we require that you pay 100% of charges rendered prior to the visit.

If you have an outstanding balance due, we appreciate the prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. Our billing department can be reached at 703-313-7700 option #8. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to over to a collection agency. In addition to the principle balance due, you will also be responsible for any legal or collection agency fees incurred.

Referrals/Prior Authorizations

Please be aware of your insurance's requirements for referrals. It is the patient's responsibility to ensure that a valid referral is on file for the services being rendered. Referrals are usually good for 30 to 60 days depending on the insurance carrier.

Please be courteous to the Primary Care Physicians (PCP) and request the referral early as some of the practices require 3 to 7 days of advance notice. The patient may need to pick up the original referral from the PCP, however, in some cases the PCP is willing to fax the referral to our office. Our referral fax number is (703) 313-4989.

Cancellations / Missed Appointments

Our automated system will attempt to contact you to remind you of your appointment 24 - 48 hours prior to your appointment. If you are unable to keep your appointment, we require a 24- hour notice of cancellation. If you fail to show for your appointment without notifying us, we reserve the right to charge you a \$50.00 no show fee that does not get covered by your insurance.

Surgical Procedure Appointments: If you do not cancel your scheduled surgery at least 10 days in advance or you fail to show for your scheduled procedure, you will be charged a \$200.00 no show fee.

Prescription Refills

We request 24 hours to refill prescriptions from time of request. Call 703 313-7700 option #2. The best way to request refills is to call your pharmacy who will contact us.

Release of Medical Records

If at any time, you would like to request a copy of your medical records, please fill out a Medical Records Release Form. The processing time is 5-7 days. We ask that you bring a photo ID with you when picking up your records. Fees are as follows:

As pursuant to Virginia Law (VA Code 8.01-413) charges will be as follows: A fee of \$15.00 for handling and a fee of \$.50 per page up to 50 pages, plus \$.25 per page for each page over 50 shall be posted to the patient account as one-line item and the payment posted against it.

Emergencies

In the event of a life threating emergency or you feel your condition requires immediate medical attention, please call 911 or go to the nearest emergency room. If you have an urgent medical need that's non-life-threatening during office hours, please call our office for instruction.

If our office is closed, our on-call doctor is available at 1(866) 624-1118. A live answering service will take your message and have the doctor call you back promptly.



6355 Walker Lane-Suite 308 Alexandria, VA 22310 PH: 703-313-7700 FAX: 703-313-0178

Diagnostic Tests/Procedures that may be Necessary to Fully Diagnose and Treat Your Condition

Metropolitan ENT & Facial Plastic Surgery physicians are pleased you have chosen them to assist in your care. Our physicians feel that a patient presenting to our office with sinus, allergy, throat, hearing or voice complaints requires a thorough examination of that specific area. In some cases, this can only be accomplished through the use of diagnostic tests/procedures, which your physician may feel is medically necessary.

THE FOLLOWING TESTS AND/OR PROCEDURES ARE SEPARATE FROM THE PHYSICIAN'S OFFICE CONSULTATION AND THUS HAVE A SEPARATE CHARGE.

- Flexible Laryngoscopy (CPT 31575) *
- Nasal Endoscopy (CPT 31231) *

*Insurance companies may consider a Nasal Endoscopy and Laryngoscopy a "diagnostic procedure" and apply them to your deductible and/or co-insurance.

Please feel free to check coverage with your insurance. CPT codes, our Tax ID and Doctors have been provided below for your convenience:

Tax ID #5419888-43 Metropolitan ENT & Facial Plastic Surgery Loudoun Medical Group

Michael R Abidin, MD Iyad S. Saidi, MD Tarek Orfaly, MD Ravi S. Swamy, MD Courtney C. Raizman, MD Richard H. Comstock III, MD

By signing this form, I have agreed to the terms and conditions listed above.

Printed Patient Name

Date of Birth

Patient/Guardian Signature

Today's Date