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

Loudoun Medical Group

PATIENT DEMOGRAPHICS

FIRST NAME: _____

MI:_____ LAST NAME: _____

PRFX/SUFFIX: _____ SSN: _____

DOB:_____ SEX: _____

STREET ADDRESS: _____

APT/UNIT # : _____

CITY/STATE: _____

ZIP: _____

EMAIL ADDRESS: _____

HOME PHONE *(include area code)*: _____

CELL PHONE *(include area code)*: _____

PCP &/or REFER PHYSICIAN: _____

PREFERRED LANGUAGE: _____

STUDENT: *Full Time* *Part Time* *Not Enrolled*

MARITAL STATUS: _____

RACE: _____

ETHNICITY: _____

CONTACT PREFERENCE: _____

EMPLOYER: _____

JOB STATUS: *Full Time* *Part Time* *Retired* *None*

EMPLOYER PHONE NUMBER: _____

PHARMACY NAME: _____ PHARMACY PHONE NUMBER: _____

I hereby authorize Metropolitan ENT to obtain/download my medical history from Pharmacies and/or Pharmacy Benefit Managers. This authorization will allow my physicians to check drug to drug interactions for any new prescriptions he/she may prescribe and to facilitate electronic pharmacy prescriptions. I understand this authorization will 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:_____

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INSURANCE POLICY INFORMATION

PRIMARY INSURANCE

NAME OF INSURANCE CO: _____

NAME OF INSURANCE CO: _____

POLICY NUMBER: _____

GROUP ID: _____

EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____

RELATION TO SUBSCRIBER: _____

SUBSCRIBER DOB: _____

SUBSCRIBER SSN: _____

SUBSCRIBER ADDRESS: _____

_____

SECONDARY INSURANCE

NAME OF INSURANCE CO: _____

NAME OF INSURANCE CO: _____

POLICY NUMBER: _____

GROUP ID: _____

EFFECTIVE DATE: _____

SUBSCRIBER NAME: _____

RELATION TO SUBSCRIBER: _____

SUBSCRIBER DOB: _____

SUBSCRIBER SSN: _____

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.
2. 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 ☐ **No Current Medications** **Today's Date:** _____

(Prescription, over-the-counter, herbal)

Medication	Dosage	How often	Reason

DRUG/NON-DRUG ALLERGIES ☐ **No Allergies**

Medication Name or Non Drug Allergy	Type of Reaction

Have you ever had Surgery or Hospitalization? ☐ **NO** ☐ **YES**

If yes list type/year: _____

_____

_____

Have you ever had problems with Anesthesia? ☐ **NO** ☐ **YES**

Have you ever had a serious injury or accident? ☐ **NO** ☐ **YES**

If yes list type of injury/date: _____

_____

If female, are you pregnant? ☐ **NO** ☐ **YES**

MEDICAL HISTORY: *Have YOU or ANYONE in your family been diagnosed with……? (check **all** that apply)*

	No	Yes	Self/Family Member		No	Yes	Self/Family Member
Alcoholism	☐	☐	_____	Glaucoma	☐	☐	_____
Anemia	☐	☐	_____	Headache (Type?)	☐	☐	_____
Angina/Heart Attack	☐	☐	_____	HIV/AIDS	☐	☐	_____
Arthritis	☐	☐	_____	High Blood Pressure	☐	☐	_____
Asthma	☐	☐	_____	Kidney Disease	☐	☐	_____
Birth Defect	☐	☐	_____	Liver Condition	☐	☐	_____
Bladder Disease	☐	☐	_____	Lung Condition	☐	☐	_____
Bleeding Disorder	☐	☐	_____	Mental Illness	☐	☐	_____
Cancer (Type?)	☐	☐	_____	Stroke	☐	☐	_____
Diabetes	☐	☐	_____	Thyroid Condition	☐	☐	_____
Emphysema	☐	☐	_____	Tuberculosis	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____	Other	☐	☐	_____

Print Name: _____ **DOB:** _____

SOCIAL HISTORY

Do you use Tobacco? ☐ Yes ☐ No ☐ Former

____No longer ____Cigarettes ____Pipe ____Cigars

Do you consume alcohol? ☐ Yes ☐ No ☐ Former

____ Beer ____ Wine ____ Coolers ____Liquor

Do you use drugs recreationally? ☐ Yes ☐ No ☐ Former

____Cocaine ____Heroin ____Marijuana ____Oxycodone ____Other

Do you use caffeine? ☐ Yes ☐ No

____1 per day ____2-3 per day ____4 or more per day

Do you have pets in the home? ☐ Yes ☐ No

____Cat ____ Dog _____Other

Do you exercise regularly? ☐ Yes ☐ No Type _____

Home Living Situation: ☐ Alone ☐ w/Spouse ☐ w/Spouse & Children ☐ w/Children ☐ w/Parents ☐ Other _____

Patient considers diet to be: ☐ Healthy ☐ Not Healthy ☐ Other: _____

Do you consider yourself generally: ☐ Healthy ☐ Fair ☐ Not Healthy

PATIENT REVIEW OF SYSTEMS: *(check all that apply to today's visit)*

Ears
□ Drainage
□ Dizziness
□ Hearing loss
□ Ringing in ears
□ Other_____

Nose & Sinus
□ Congestion
□ Drainage
□ Itchy nose
□ Nosebleeds
□ Runny nose
□ Sneezing
□ Snoring
□ Other

Throat & Mouth
□ Hoarseness
□ Inflammation of Throat
□ Sore throat
□ Sore tongue
□ Sores in Mouth
□ Swallowing difficulty
□ Popping sound in mouth or ear (TMJ)
□ Hives
□ Snoring
□ Ulcers
□ Voice change
□ Other _____

Allergic, Infections, Immune System
□ Dark circles under eyes
□ Food intolerance
□ Hives
□ Itchy Nose
□ Infections (recurring)
□ Mouth breathing
□ Other _____

Cardiovascular (Heart and Blood Vessels)
□ Blacking Out
□ Chest pain
□ Irregular heartbeat
□ Swelling
□ Other _____

Hematologic
□ Masses
□ Other _____

Genitourinary
□ Urination at night
□ Other _____

Eyes
□ Blurred vision
□ Double vision
□ Itchy eyes
□ Sensitivity to light
□ Other _____

Integumentary (Skin)
□ Bruises easily
□ Dryness
□ Itching
□ Moles that have changed
□ Other_____

Gastrointestinal (Stomach)
□ Abdominal pain
□ Blood in stool
□ Diarrhea
□ Other _____

Respiratory (Lungs and Respiratory System)
□ Cough, non-productive
□ Cough, productive
□ Coughing up blood
□ Sleep disturbance due to breathing
□ Pain/tightness in chest
□ Wheezing
□ Other _____

Neurological (Nerves)
□ Numbness
□ Other _____

Psychiatric
□ Depression
□ Feels sad more than usual
□ Other _____

Endocrine
□ Appetite is increased
□ Fatigue
□ Neck has enlarged
□ Other _____

Musculoskeletal
□ Loss of muscle strength
□ Other _____

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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.

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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