LOUDOUN MEDICAL GROUP

Account Number

PATIENT INFORMATION

Last Name	First Name	Middle Initial	
Street Address		City/State	Zip Code
Home Telephone		Emergency Telephone	Emergency Contact
Social Security Number	Date of Birth (mm,dd,yy)	Sex: Male / Female	Single / Married / Divorced / Widowed
Preferred Provider (PCP)	Preferred Pharmacy Name/Phone Number	School Name/Phone Number (if applicable)	
Employer	Employer Address/Phone Number		

RESPONSIBLE PARTY/BILLING INFORMATION

Last Name	First Name	Middle Initial	
Street Address (if different from above)		City/State	Zip Code
Home Telephone		Employer Phone	
Employer	Employer Address		
Social Security Number			

PRIMARY INSURANCE INFORMATION

Name of Company		Office Co-Pay $	Insurance Telephone
Group Number		Policy Number	
Insurance Address		City/State	Zip Code
Insured's Name	Date of Birth	Relationship	Social Security Number
Insured's Employer	Address/State/Zip Code		Telephone

SECONDARY INSURANCE INFORMATION

Name of Company			Insurance Telephone
Group Number		Policy Number	
Insurance Address		City/State	Zip Code
Insured's Name	Date of Birth	Relationship	Social Security Number
Insured's Employer	Address/State/Zip Code		Telephone

PATIENT AUTHORIZATION

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 agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I 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.

Signature　　　　　　　　　　　　　　　　　　　　Date

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