HEART & VASCULAR SPECIALISTS, PC

LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Date ____________________ **Account Data Sheet**

Dear Patient: Kindly complete the data shown below for your contact information.
Note especially the authorizations for family or care takers access.

Patient ______________________________________

Date of Birth _________________________________

Address _____________________________________

City, State and Zip Code _______________________

Home Phone # ______________________________

Cell Phone # ________________________________

Email Address _______________________________

Primary Doctor ______________________________

Lab Preference ______________________________

Marital Status (circle one): S M D W

Employment Status: Active Disabled Retired Unemployed

Employer if Applicable ________________________

Employer City/State __________________________

Work Phone # _______________________________

Additional Information (collected in compliance with the National Committee for Healthcare Assurance)

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: ______________
Sexual Orientation:□ Straight/heterosexual □Lesbian, gay/homosexual □Bisexual □Don't know □Choose not to disclose.

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1) I hereby authorize my insurance company to pay benefits to Heart and Vascular Specialists, Loudoun Medical Group for services rendered.
2) By signing this consent form, you are granting written consent to Heart and Vascular Specialists, LMG to provide medical treatment and access your medication list history without any restrictions. You have the right to inquire about the cost and reason for any services ordered by your physician. Heart and Vascular Specialists, LMG has the authority to disclose your Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations. Any other individual request for your PHI other than "incidental", will require your signature releasing those records requested. {Such as life insurance applications, disability benefits, etc.}
3) I consent to receive phone calls, test messages, and email as a form of communication.
_____A. Phone Calls _____B. Text Messages _____C. Emails
4) I acknowledge that on request, I may view Heart and Vascular Specialists, Loudoun Medical Group's Privacy Notice.
5) I consent to Heart and Vascular Specialists, LMG's Medication History Authority.
6) We reserve the right to purge records after 10 years of inactivity.
7) You have the right at any time to revoke this consent in writing. Direct revocation to the Office Manager.
8) Please list any person you would like to authorize to have access to your billing, appointment, or health information such as your spouse, caregiver, or family member:

NAME	RELATIONSHIP	PHONE
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

____ ____________________________________

Signature of Patient/ Legal Guardian Date Signature of Witness Date

Print Name ______________________________ Print Name ___________________________