

LOUDOUN PEDIATRIC ASSOCIATES

(Name must appear as on the insurance card!!!) **PATIENT INFO** (Please list ALL children in the family!)

Last Name	First Name (No Nicknames Please!)	D.O.B.	Male/Female
Last Name	First Name (No Nicknames Please!)	D.O.B.	Male/Female
Last Name	First Name (No Nicknames Please!)	D.O.B.	Male/Female
Last Name	First Name (No Nicknames Please!)	D.O.B.	Male/Female
Last Name	First Name (No Nicknames Please!)	D.O.B.	Male/Female
Last Name	First Name (No Nicknames Please!)	D.O.B.	Male/Female
Mailing Address of Above Children		City/State	Zip Code
Home #	Email address:		

PRIMARY INSURANCE INFO (This is the Insurance Policy Holder)

Name of Policy Holder		SSN	D.O.B.
Mailing Address (if different from above)		City/State	Zip Code
Home #	Work #	Cell #	
Male/Female	Relationship to Patient(s)		
Insurance Co. Name	Copay \$	Policy #	Effective Date: Group #
Employer Name		Employer Work Address	

PLEASE NOTE THAT ONE OF THE LPA PROVIDERS' NAMES MUST BE LISTED ON INSURANCE CARD TO INSURE PROPER PAYMENT.

We need to see insurance card at EVERY visit.

OTHER PARENT CONTACT INFO (MOM or DAD)

Last Name	First Name	SSN	D.O.B.
Mailing Address (If different from above)		City/State	Zip Code
Home # (If different from above)	Cell # (If different from above)	Work # (If different from above)	
Male/Female	Relationship to Patient(s)		
Employer	Work Address		
Emergency Contact (Other than Parents!)		Emergency Home #	Emergency Cell #

AUTHORIZED NON-PARENTS WHO MAY BRING PATIENTS TO THE OFFICE

PLEASE LIST NAMES. We will ask that these individuals show a government-issued ID when bringing your child or children to our office.

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 Loudoun Medical Group, PC (LMG) 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/s 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 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 Occupation Safety and Health Administration.

SIGNATURE

DATE

Please turn this page over and review and sign our Patient Responsibilities Form.