Lansdowne Internal Medicine, LLC **Patient Registration Form**

Section I: **Patient Information** **Date:**_____

Name:_____ **Preferred Name:**_____ **Date of Birth:**_____

Address:_____

City:_____ **State:** _____ **Zip:** _____ **Social Security Number:**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **ext.** _____

Race: _____ **Ethnicity:** _____ **Language:** _____ **Sex:** _____

Employment Status: _____ **Employer Name:** _____ **Student Status:** _____

Marital Status: **Minor** **Single** **Married** **Widowed** **Separated** **Divorced**

Preferred Local Pharmacy: _____ **Preferred Mail Order:** _____
(City/State)

Section II: **Eligible Dependent Info**
(Please complete this section ONLY if you are financially responsible for any persons between the ages of 17-24 and wish to have them enrolled in the MDVIP dependent program)

Child Name: _____ **Age:** _____ **Sex:** _____

Child Name: _____ **Age:** _____ **Sex:** _____

Child Name: _____ **Age:** _____ **Sex:** _____

Child Name: _____ **Age:** _____ **Sex:** _____

Child Name: _____ **Age:** _____ **Sex:** _____

I understand and agree that I am ultimately responsible for payment. I certify that this information is true and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Accepted By: _____

Lansdowne Internal Medicine, LLC **Patient Registration**

Section III: **Insurance Information**

Primary Insurance

Name of Policy Holder: _____ **DOB:** _____ **Relationship:** _____

SSN #: _____ **Name of Employer:** _____ **Work #:** _____

Insurance Company: _____ **ID #:** _____

Group # _____ **Policy Effective Date:** _____

Secondary Insurance

Name of Policy Holder: _____ **DOB:** _____ **Relationship:** _____

SSN #: _____ **Name of Employer:** _____ **Work #:** _____

Insurance Company: _____ **ID #:** _____

Group # _____ **Policy Effective Date:** _____

Tertiary Insurance

Name of Policy Holder: _____ **DOB:** _____ **Relationship:** _____

SSN #: _____ **Name of Employer:** _____ **Work #:** _____

Insurance Company: _____ **ID #:** _____

Group # _____ **Policy Effective Date:** _____

Self Pay/ Not Insured: Yes: _____ **(please initial if you do not have a medical insurance plan)**

I understand and agree that I am ultimately responsible for payment. I certify that this information is true and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Accepted By: _____

ASSIGNMENT AUTHORIZATION

Welcome to Lansdowne Internal Medicine, LLC. It is our mutual benefit that our patient's understand our Payment Policy. If your insurance company is one with which we participate with, we will bill your insurance company as agreed between Lansdowne Internal Medicine, LLC and the respective insurance company. Ultimately, responsibility for payment lies with the patient. Payment not received from the insurance company within 45 days becomes the responsibility of the patient. If you do not have insurance, or you have one which we do not participate with, full payment is expected at the time services are rendered. Please sign the following authorization so that payment may be made to Lansdowne Internal Medicine, LLC for services rendered and billed by Lansdowne Internal Medicine, LLC.

Patient Signature_____

OUR PAYMENT POLICY

I, the undersigned, hereby authorize Lansdowne Internal Medicine, LLC to apply for benefits on my behalf for covered services rendered to me, not paid in full today.

I certify that the information reported with regard to insurance coverage is correct and further authorized the release of necessary information, including medical information, for this or any related claim, to my insurance carrier. In making this assignment, I understand and agree that I am financially responsible for charges not paid under this insurance policy.

GUARANTEE OF PAYMENT

To Lansdowne Internal Medicine, LLC: For and in consideration of services rendered, or to be rendered to the patient. I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. In the event the account must be placed with an outside collection agency or attorney to obtain payment, I shall be responsible for all collection agency and attorney fees incurred.

THE UNDERSIGNED HAS READ, UNDERSTANDS, AND AGREES TO THE ABOVE TERMS AND CONDITIONS.

Signature_____ Date: _____

Accepted By: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM
LANSDOWNE INTERNAL MEDICINE
224D CORNWALL ST. NW, SUITE 302
LEESBURG, VA 20176
Phone: 703-737-7740
Fax: 888-857-3550

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying this consent.

Please list the family members or other persons, if any, whom we may leave messages with or inform about your general medical condition and your diagnosis (including treatment, payment, appointments and other medical care operations):

Primary Emergency Contact: _____Relationship:_____
Phone: _____ FullAccess Limited Access (**please circle**)

Name: _____ Relationship: _____
Phone: _____ FullAccess Limited Access (**please circle**)

Name: _____ Relationship: _____
Phone: _____ FullAccess Limited Access (**please circle**)

Name: _____ Relationship: _____
Phone: _____ FullAccess Limited Access (**please circle**)

Please indicate below if we may leave confidential messages on your home and cell phone answering machine or voicemail:

	Home Phone	**Cell Phone**	**Work Phone**
Lab Results-	Yes or No	Yes or No	Yes or No
Appointment Reminders-	Yes or No	Yes or No	Yes or No
Medication Refills-	Yes or No	Yes or No	Yes or No

Patient Name: _____ Signature: _____
Relationship to Patient: _____ Date: _____

LANSDOWNE
INTERNAL MEDICINE

Telephone: 703-737-7740

224-D Cornwall Street
Suite 302
Leesburg, VA 20176

Fax: 888-857-3550

Lansdowne Internal Medicine, LLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses "secure sockets layer technology", you can read or view information on your computer. It is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and we are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and I consent to the conditions outlined herein. I also agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

____Please register me for portal using the following email address: _____

____I choose not to enroll at this time.

Signature_____ Date_____

LANSDOWNE
INTERNAL MEDICINE

224-D Cornwall Street
Suite 302
Leesburg, VA 20176

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CONSENT FORM FOR TEXT MESSAGING

By signing below, I give consent to receive text messages from Lansdowne Internal Medicine. As part of this consent, you represent and warrant the following:

(1) Lansdowne Internal Medicine or others acting on their behalf may send text messages in various formats and with various contents, including but not limited to, text messages about appointment reminders & medication refill notifications.

(2) You are the owner or authorized user of the mobile phone number identified below. You will notify us immediately if you are no longer the owner or authorized user of the mobile phone number identified below.

(3) You are solely responsible for any message and data charges associated with such text messages.

Printed Name Date of Birth Today's Date

Signature Mobile Number

*****Please note*****

1. Limited information will be sent since this is not considered a secure form of communication.
2. The system does not allow for reply messages to be received.