

**MARTIN J. O'HARA, M.D., F.A.C.C.**

1635 N. George Mason Dr, Ste 150

Arlington, VA 22205

703-247-2901 Fax 703-807-0082

www.drmartinohara.com

**PATIENT DEMOGRAPHIC FORM**

<b>Patient Information</b>	Last Name		First Name		Middle Initial		Today's Date		
	Street Address				City		State	Zip	
	Home Phone ( )		Work Phone ( )		Cell Phone ( )		I agree to have reminders sent by text message <input type="checkbox"/>		
	Social Security Number		Date of Birth		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status		
	Race	Ethnicity	Preferred Language		Email address		I agree to have reminders sent to my email address <input checked="" type="checkbox"/>		
	Allergies		Allergy Location		Allergic Reaction		Allergic Severity		
	Smoking Status <input type="checkbox"/> Current Smoker <input type="checkbox"/> Past Smoker <input type="checkbox"/> Never Smoked			Cigarettes Per Day (if applicable)		Effective Date (if applicable)			
<b>Emergency Contact</b>	Name				Relationship to Patient				
	Home Phone ( )		Preferred <input type="checkbox"/>		Work Phone ( )		Preferred <input type="checkbox"/>		Cell Phone ( )
<b>Referral Info</b>	Referring Physician's Name				Physician Phone (if known) ( )		Physician Fax (if known) ( )		
	Physician Address (if known)				City		State	Zip	
<b>Insurance Information</b>	Primary Insurance Company				Policy #		Group #		
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)					
	Subscriber's SSN		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber		Work Phone ( )		
	Secondary Insurance Company				Policy #		Group #		
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)					
Subscriber's SSN		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Employer of Subscriber		Work Phone ( )			

Form revised: 7/5/13

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction; but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The Practices provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time, and all future disclosures will then cease.
- The Practice may post Protected Health Information online as part of your Electronic Health Record, which is password-protected and encrypted.
- The Practice may condition treatment upon the execution of this Consent.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature Relationship to Patient

(If signed by personal representative of Patient)

\_\_\_\_\_  
Witness (Employee)

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**ASSIGNMENT OF BENEFITS & PAYMENT/CREDIT AGREEMENT**

(This is necessary to facilitate the processing of insurance claims and assure payment)

1. I hereby authorize and give permission for Martin J. O'Hara to disclose my personal health information (\*PHI) for insurance and treatment purposes only. I am allowing Martin J. O'Hara, MD to release all PHI necessary for payment and treatment of my specific health problem.
2. I hereby assign to you, my doctor, all medical and surgical benefits to which I am entitled, including any deductibles and co-payments, and that the payments are due at the time of services are rendered.
3. I understand that I am financially responsible for all charges not paid by said insurance company, including any deductibles and co-payments, and that payments are due at the time services are rendered.
4. I understand that NO SHOWS AND CANCELLATIONS LATER THAN THE PREVIOUS BUSINESS DAY WITHOUT A SERIOUS/SUBSTANTIVE REASON WILL BE CHARGED \$25.
5. I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and agree to pay the collection agency's fee for collections, court costs and/or reasonable attorney fees that may be incurred in the collection of any outstanding balance.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Please refer to Martin J. O'Hara, MD posted "Notice of Privacy Practice" for specific information regarding this practice's use of personal health information (PHI).

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**ESTABLISHED PATIENTS ONLY:**

Your insurance company requires that we have an updated signature on file annually.

By signing, I am certifying that my information is correct and up to date.

Updated: \_\_\_\_\_  
Signature Date

Updated: \_\_\_\_\_  
Signature Date

Updated: \_\_\_\_\_  
Signature Date

Updated: \_\_\_\_\_  
Signature Date