Martin J. O'Hara, M.D., F.A.C.C.
611 S Carlin Springs Road
Suite 409
Arlington, VA 22204
Phone: (703) 247-2901 Fax: (703) 988-2404
www.drmartinohara.com

PATIENT DEMOGRAPHIC FORM

Patient Information

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 ☐
( )	( )	( )	

Social Security Number	Date of Birth	Gender	Marital Status
		☐ Male ☐ Female	

Race	Ethnicity	Preferred Language	Email address	I agree to have reminders sent to my email address œ

Allergies	Allergy Location	Allergic Reaction	Allergic Severity

Smoking Status	Cigarettes Per Day (if applicable)	Effective Date (if applicable)
☐ Current Smoker ☐ Past Smoker ☐ Never Smoked		

Emergency Contact

Name	Relationship to Patient

Home Phone	Work Phone	Cell Phone
( ) Preferred ☐	( ) Preferred ☐	( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone (if known)	Physician Fax (if known)
	( )	( )

Physician Address (if known)	City	State	Zip

Insurance Information

Primary Insurance Company	Policy #	Group #

Patient's Relationship to Insured	Name of Subscriber (if other than patient)
☐ Self ☐ Spouse ☐ Child ☐ Other _______________	

Subscriber's SSN	Gender	Date of Birth	Employer of Subscriber	Work Phone
	☐ Male ☐Female			( )

Secondary Insurance Company	Policy #	Group #

Patient's Relationship to Insured	Name of Subscriber (if other than patient)
☐ Self ☐ Spouse ☐ Child ☐ Other _______________	

Subscriber's SSN	Gender	Date of Birth	Employer of Subscriber	Work Phone
	☐ Male ☐ Female			( )

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 contracting 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 **$30.**
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).

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