Sterling Pediatrics
46175 Westlake Drive Suite 120
Potomac Falls, VA 20165
(P) 703-444-0100
(F) 703-444-7600

DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	SEX	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please circle one)* Single Married Divorced Widowed Partner	STUDENT *(please circle one)* No Full Time Part Time
STREET ADDRESS	CITY/STATE	ZIP CODE
HOME PHONE *(include area code)*	WORK PHONE	CELLPHONE
RACE *(please circle one)* White Black/African American Asian Hawaiian/Other Pacific Islander Other Race American Indian/Alaska Native	ETHNICITY *(please circle one)* Hispanic or Latino Not Hispanic or Latino Unknown	PREFERRED LANGUAGE English Spanish Or other:_____

EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
PREFERRED PHARMACY	PHARMACY PHONE NUMBER	EMAIL ADDRESS	

CONTACT/GUARANTOR INFORMATION

CONTACT *(please circle at least one)* Emergency Contact **Next** of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE

EMPLOYER	WORK PHONE	JOB TITLE

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

CONTACT *(please circle at least one)* Guarantor Emergency Contact **Next** of Kin Insured Authorized to Seek Treatment	LAST NAME	FIRST NAME	MIDDLE INITIAL
SSN *(social security number)* DATE OF BIRTH *(mm/dd/yy)*	RELATIONSHIP TO PATIENT	SEX	MARITAL STATUS
HOME ADDRESS	CITY/STATE	ZIP CODE	HOME PHONE
EMPLOYER	WORK PHONE	JOB TITLE	

NOTES

PRESENCE OF ADVANCE DIRECTIVE? Yes No	LIVING WILL? Yes No	PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT? Yes No
DURABLE POWER OF ATTORNEY? Yes No	HEALTH PROXY? Yes No	*NIA* FOR PEDIATRIC PRACTICES

INSURANCE POLICY INFORMATION

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $ Specialist: $
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOME PHONE
INSURED'S MAILING ADDRESS	PRIMARY CARE PHYSCIAN (PCP) & or REFERRING PHYSICIAN		

SECONDARY INSURANCE INFORMATION (if applicable)

POLICY NUMBER	GROUP ID		EFFECTIVE DATE
TYPE (please circle one only) Health Auto Work. Comp. Other	PRIMARY INSURANCE? Yes No	END DATE	COPAYMENT AMOUNT Office: $ Specialist: $
NAME OF INSURANCE COMPANY/PLAN	INSURANCE COMPANY ADDRESS		PHONE NUMBER
INSURED'S NAME	DATE OF BIRTH *(mm/dd/yy)*		HOMEPHONE

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HIPAA CONSENT FORM:

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 LMG, PC, or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG, PC or any of its affiliates. I also 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 Occupational Safety and Health Administration.

Sincerely,
Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

_____

Date

_____

Relationship (if any)

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MEDICATION HISTORY CONSENT

I give permission for Loudoun Medical Group to access my pharmacy benefits data electronically through RXHub/SureScript. This consent will enable Loudoun Medical Group to:

1) Determine the pharmacy benefits and drug co pays for a patient's health plan.
2) Check whether a prescribed medication is covered (in formulary) under a patient's plan.
3) Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
4) Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so. e-prescribe to these pharmacies.
5) Download a historic list of all medications prescribed for a patient by any provider.
6) Also. this is notice that Loudoun Medical Group has consent to utilize the Virginia Prescription Monitoring Program on all patients prescribed controlled substances.
7) In summary, we ask your permission to obtain formulary infom1ation, and information about other prescriptions prescribed by other providers using RX Hub and Virginia Prescription Monitoring Program.

Sincerely,

Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

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NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by§ 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.l(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a LMG health care professional worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis Band C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it

Sincerely,
Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

_____

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Receipt of Notice of Privacy Practices Acknowledgement

Patient's Name: _____

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

Sincerely,
Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

_____

Date

_____

Relationship (if any)

FOR OFFICE USE ONLY IF REFUSED TO SIGN
I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Staff Initials: _____

Refused to sign:
Reasoning –

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Wellness Check Late Fee Form

Dear Parents,
Please be advised that starting January 1ST, 2016, if you are more than 15 minutes later for your scheduled Well-Child appointment, you will be asked to reschedule. If you are willing to wait, we will do our best to see you at the end of our appointment schedule. Otherwise, we will reschedule you for the next available appointment.

If time permits, our staff "MAY" call to remind you of your scheduled appointment. However, should you not receive a reminder telephone call; this will not be accepted as an excuse for a cancelled or no-show appointment. It is the patients/parent's responsibility to update information at the front desk. As a result you will get billed a $25 NO SHOW FEE on weekdays and $50 on weekends.

We appreciate your understanding and cooperation.

Sincerely,
Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

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Sterling Pediatrics After-Hours Emergency Line Policies

The providers at Sterling Pediatrics are available 24/7 via an after-hours emergency line. This service is offered free of charge to patients of the practice, **though a fee may be incurred for improper usage.** Please review the updated policies below to avoid any unnecessary fees.

1. All **non-emergency** calls will be charged a fee of $25
2. Calls to the after-hours line should be reserved for non-business hours only.
3. The after-hours line is **not meant for appointment scheduling.** To schedule appointments, please call the office directly at 703-444-0100 during business hours.
4. If you need a prescription refill, please call the office directly during **business hours only.** Requests for prescription refills after hours will result in a $25 fee per prescription.
5. Calls to the after-hours line should be regarding ESTABLISHED patients of the practice only. The providers **are not liable to** and **will not address any health issue** that does not involve a previously established Sterling Pediatrics patient.
6. Multiple calls for the same problem will be charged a fee of $25 unless specified by the provider
7. Emergency calls will continue to be free of charge. These include calls for:
    - High fevers (> 103°F for children >3 months of age or> 100.4 for children<3 months of age)
    - Persistent vomiting
    - Seizures
    - Difficulty breathing or wheezing
    - Trauma or injury
8. **Calls should be brief** and include specific information (for example, medication names and dosages). Parents seeking extensive after-hours phone consultations will be charged a fee of $25.
9. Providers are happy to address all non-emergency calls during office hours at no cost to our patients.

We sincerely thank you in advance for your cooperation with and adherence to the above outlined polices.

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Sterling Pediatrics After-Hours Emergency Line Policies

I acknowledge that I have reviewed and received the updated after-hours emergency line policies for Sterling Pediatrics and agree to adhere to these policies. I understand that failure to adhere to these policies may result in a monetary fee.

Sincerely,
Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

_____

Date

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Wellness Check Consent Form

What is the difference between a physical and an office visit?

We would like to help our patients and parents understand the difference between an **OFFICE VISIT** and a **PHYSICAL**. This is especially important when *we* submit a bill to your insurance company for that visit. This will help you get the right service and help us serve your needs as best *we* can. When scheduling an appointment, our office tries to figure out how much time you need with the doctor and whether you need a physical or an office visit.

An **"office visit"** is an appointment time to discuss new or existing problems. The questions and exam will focus on the problems discussed. This may include prescribing medications, ordering additional tests like lab or x-ray, in-office procedures, referrals to specialists, or discussing other treatment options.

A **" physical"** or **"preventive health exam"** is a thorough review of your general well-being. This exam will review your medical problems, perform a complete physica.1 examination and recommendations will be made concerning your health. This may include general recommendations regarding diet and exercise age-appropriate immunizations and lab work. Ongoing chronic medical problems and medication ref ill s can be addressed as long as the condition is stable and does not require a significant change in treatment or additional tests.

We highly encourage scheduling these appointments on separate days to allow time to fully discuss either your well-being or your new condition during the allotted appointment time. However. on occasion items brought up during your physical exam may result in you being seen for both a **“physical”** and an **"office visit"** on the same day. This means that you satisfy the requirements for both types of visits during one appointment. For example, if you scheduled a physical but also discussed an additional problem that requires an additional evaluation and the evaluation took place during that appointment and addressed the problem separately from the physical, then you would be billed for both a physical and an office visit during the same appointment. We hope this information is helpful. We want to provide you with the highest quality medical care possible.

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Wellness Check Consent Form

I have read and understand the differences outlined above.
By signing below, I acknowledge and understand there may be additional charges during a physical exam when new or additional problems are discovered and addressed during the exam.

Sincerely,
Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

_____

Date

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Wellness Check Insurance Confirmation Form

What does this mean?

If your "physical" is scheduled less than 365 days from the prior "physical" the year before, there is a chance it would not be covered by your insurance, which would result in the responsible party receiving a statement with the full amount of the wellness visit or "physical". To avoid this, call your insurance and make sure you understand the terms of your contract and when you can schedule the next wellness check-up or "physical"

What is this form?

This is a consent form stating the following:

1. Sterling Pediatrics is not liable for anything that is not covered by your insurance and should be dealt with either your insurance or the billing department.

2. It is your responsibility to check with your insurance to make sure you can have wellness check or "physical" every year at anytime or it has to be after the last "physical" date from the year prior

Sincerely,
Providers and Staff at Sterling Pediatrics

_____

Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis

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Date

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Patient Name: _____ Patient DOB: _____

CONSENT FOR HEALTH INFORMATION EXCHANGE

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell Health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Please initial beside the option of your choice:

Opt In: Send and Receive Documents

X_____ Loudoun Medical Group will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records.

Opt Out

X_____ Loudoun Medical Group will neither send clinical documents to nor request clinical documents from external connected sites.

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting Loco Parentis Date

_____
Relationship (if any)