Coleman Primary Care

Completed Date: _____

PATIENT INFORMATION

Personal Information*

Prefix: Mr./Mrs./Other: _____ Patient*: _____ Suffix: Jr./Sr./Other: _____
(Last, First, Middle Initial)

Previous Name: _____ Preferred Name: _____

Mailing Address*: _____
(Street Address, City, State, Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Method of Contact for Appointment Reminders: ☐ Text Message ☐ Home Phone ☐ Cell Phone

Primary Care Provider (PCP): _____ Address: _____ Phone #: _____
(First, Last)

Referring Provider: _____ Address: _____ Phone #: _____
(First, Last)

Date of Birth*: _____ Sex*: _____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
(mm/dd/yyyy)

Social Security #: _____ - _____ - _____ Employer Name: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A

Additional Information*

Email: _____

Race*: ☐ Caucasian/White ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: _____

Language*: ☐ English ☐ Spanish ☐ Other: _____

Pharmacy Name*: _____ Address: _____ Phone #: _____
(Street Address, City, State, Zip)

Emergency Contact*

Name: _____ Relationship: _____
(Last, First)

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Work #: _____ Cell #: _____

Parent / Guardian Information* - Required if the patient is under 18 years of age

Name: _____ Date of Birth: _____ Sex: _____Social Security #: _____ - _____ - _____
(Last, First) (mm/dd/yyyy)

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Primary Insurance Information*

Insurance Name: _____ Member ID #: _____ Relationship to Insured: _____

Employer: _____Group #: _____ Effective Date: _____
(mm/dd/yyyy)

Insured's Information* - (if not self)

Name: _____ Date of Birth: _____ Sex: _____ Social Security #: _____ - _____ - _____
(Last, First) (mm/dd/yyyy)

Relationship to Insured: _____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Work #: _____ Cell #: _____

Secondary Insurance Information

Insurance Name: _____ Member ID #: _____ Relationship to Insured: _____

Group #: _____ Effective Date: _____

Secondary Insured's Information - (if not self)

Name: _____ Date of Birth: _____ Sex: _____ Social Security #: _____ - _____ - _____
(Last, First) (mm/dd/yyyy)

Relationship to Insured: _____ Marital Status*: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address: _____
(Street Address, City, State, Zip)

Home #: _____ Work #: _____ Cell #: _____

CONSENT INFORMATION

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**. X _____ (Please initial)**

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:

If any LMG health professional, worker or employee should be directly exposed to your blood or your 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- 45.1(A), you are deemed to have consented to the release of the test results to the person exposed. **X _____(Please initial)**

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 transit disease, that person's 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 and that person the result of the test. **X _____ (Please initial)**

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:

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

_____ _____

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

_____

Relationship (if any)

Coleman Primary Care

Phone: 703-430-7090 | Fax: 703-444-9878 | 2 Pidgeon Hill Drive, Suite 400, Sterling, VA 20165

MEDICAL HISTORY

Please take a moment to fill out this medical history form so that your practitioner can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

If you are new to this clinic, who was your previous primary care physician? _____

Patient's Full Name:_____ Today's Date: _____

DOB:_____Height:_____Weight:_____ Blood Type: _____

MEDICATION LIST

Date Started	Medication and Dose	Directions	Date Stopped	Reason for Taking	Prescribed By

PAST MEDICAL HISTORY

1. Please list any active medical problems for which you are currently being treated, such as hypertension, diabetes, high cholesterol, asthma, and seizures.

   _____

   _____

2. Please list your surgeries with the date(s)

   _____

   _____

3. Please list your non-surgical hospitalizations with the date(s)

   _____

   _____

4. Please list any major accidents or injuries with the date(s)

   _____

   _____

PREVENTION INFORMATION

Have you ever had (and date):

Flu Vaccine_____Hepatitis B Vaccine_____Pneumonia Vaccine _____

Hepatitis A Vaccine_____Tetanus Vaccine_____Gardasil Vaccine _____

Meningitis Vaccine_____PPD/TB Test _____

Do you use seat belts? ☐Yes ☐No

Do you have smoke detectors in your home? ☐Yes ☐No

Do you have a loaded firearm in your home? ☐Yes ☐No If yes, how is it stored?

SOCIAL HISTORY/LIFESTYLE

Where were you born and raised?_____How long have you been in this area? _____

Do you still drive an automobile? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

If married, spouse's name_____

Who lives at home with you? _____

Occupation _____ Hobbies _____

Children(s) names and ages

Do you ride a motorcycle/bicycle? ☐Yes ☐No Do you wear a helmet? ☐Yes ☐No

Do you smoke or use nicotine products? ☐Yes ☐No How many years?_____

Cigarettes (# Packs/day)_____ Cigars_____ Pipe_____ Chew Tobacco_____

Have you ever used recreational drugs? ☐Yes ☐No If yes, when was the last time?_____

What kind did you use? _____

Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products? ☐Yes ☐No If yes, which ones and how often? _____

Do you take something to help you sleep? ☐Yes ☐No If yes, what and how often? ___

Do you restrict your diet in any way? ☐Yes ☐No If yes, how?

Do you drink alcohol? ☐Never ☐Occasionally ☐Daily

If yes, how many days per week do you drink alcohol?_____

On a typical day when you drink, how many drinks do you have?_____

Do you drink caffeine? ☐Yes ☐No If yes, how much?_____

Ever worked with chemicals, paints, asbestos, or any haz. material? ☐Yes ☐No If yes, what kind? _____

FAMILY HISTORY

How many children do you have? ☐None Sons_____Daughters _____

Are all alive and in good health? ☐Yes ☐No If no, please explain _____

How many siblings do you have? ☐None Brothers_____Sisters _____

Are they alive and well? ☐Yes ☐No If no, please explain _____

Is your father still living? ☐Yes ☐No If yes, major health problems / if no, cause of death _____

Is your mother still living? ☐Yes ☐No If yes, major health problems / if no, cause of death _____

Is there a family history - father, mother, sister, brother, maternal/paternal grandparents of:

Relative	Diabetes	Alcoholism	Drug Abuse	High Cholesterol	Suicide	Depression	Cancer (type)
Father							
Mother							
Sibling							
M. Grandmother							
M. Grandfather							
P. Grandmother							
P. Grandfather							
Other							

Patient's Name: _____

SYSTEMS REVIEW

General - Have you noticed:

Significant weight change (>10 lbs) in the past 6 months? ☐No ☐Yes, Increase _____lbs. Decrease____lbs.

Significant recent appetite change? ☐Yes ☐No If yes, ☐Increase ☐Decrease

Significant sweating or night sweats? ☐Yes ☐No

Skin – Have you had:

Recent rashes, lumps, or other skin / hair / nail problems? ☐Yes ☐ No _____

A history of skin cancer? ☐Yes ☐No

Eyes – Have you had:

Recent vision changes? ☐Yes ☐No Last eye appointment: With whom?_____

Glaucoma/Cataracts? ☐Yes ☐No

Ears / Nose / Mouth / Throat – Have you had:

Hearing problems? ☐Yes ☐No

Do you have / use hearing aides? ☐Yes ☐No

Frequent wax impaction? ☐Yes ☐No Frequent nosebleeds? ☐Yes ☐No

Do you have a history of Obstructive Sleep Apnea? ☐Yes ☐No If yes, do you use a CPAP? ☐Yes ☐No

Do you snore? ☐Yes ☐No Do you have excessive daytime fatigue? ☐Yes ☐No

Do you notice SIGNIFICANT dizziness, vertigo? ☐Yes ☐No

Cardiovascular - Do you get:

Chest pain / pressure / tightness / squeezing / discomfort? ☐Yes ☐No

If yes, does it occur with activity or exertion? ☐Yes ☐No

Heart fluttering / flip-flops / skipping or palpitations? ☐Yes ☐No

Swelling of ankles? ☐Yes ☐No

Pain in legs while walking? ☐Yes ☐No

Shortness of breath? ☐Yes ☐No

Do you take antibiotics before dental work?

Do you exercise on a regular basis? ☐Yes ☐No How often? _____ What type? _____

Respiratory – Have you ever been told that you have:

Asthma? ☐Yes ☐No Emphysema/chronic bronchitis? ☐Yes ☐No Blood clots/ leg or lung? ☐Yes ☐No

Tuberculosis (TB) or positive skin test? ☐Yes ☐No

Do you notice frequent: Wheezing / Shortness of breath? ☐Yes ☐No

Coughing / Phlegm production? ☐Yes ☐No Coughing up blood? ☐Yes ☐No

Gastrointestinal – Do you notice:

Frequent nausea or vomiting? ☐Yes ☐No Diarrhea? ☐Yes ☐No

Significant constipation? ☐Yes ☐No

Bloody or black bowel movements? ☐Yes ☐No

Frequent heartburn / indigestion? ☐Yes ☐No

Do you take antacids? ☐Yes ☐No If yes, how often? _____

Trouble swallowing? ☐Yes ☐No

Abdominal Pain? ☐Yes ☐No

Have you ever been diagnosed with: ☐Ulcers ☐Hepatitis ☐Colitis

Have you ever had a colonoscopy? ☐Yes ☐No If yes, when? _____

Patient's Name: _____

Genitourinary – Do you notice:
Burning / frequency or hesitation with urination? ☐Yes ☐No
Do you wake up in the night to urinate? ☐Yes ☐No
Do you have difficulty starting your urine stream? ☐Yes ☐No
Do you have problems holding your urine? ☐Yes ☐No Do you wear a pad for incontinence? ☐Yes ☐No
Have you ever had kidney stones? ☐Yes ☐No If yes, last episode? _____
Are you sexually active? ☐Yes ☐No
Problems with your sex drive? ☐Yes ☐No Abnormal discharge? ☐Yes ☐No
Have you ever had a sexually transmitted disease? ☐Yes ☐No If yes, what type? _____
What kind of birth control do you use? _____
Do you use condoms? ☐Always ☐Most of the time ☐Rarely ☐Never
Ever engaged in any activity to put you at risk for aids? ☐Yes ☐No If yes, explain _____
Women – Do you have or have you had:
Problems related to menopause? ☐Yes ☐No Prolonged or abnormal bleeding? ☐Yes ☐No
Pelvic pain? ☐Yes ☐No Do you want an AIDS test? ☐Yes ☐No
Have you ever been physically or sexually abused? ☐Yes ☐No If yes, would you like to discuss? _____
Do you feel safe in your current home/environment? ☐Yes ☐No
An abnormal pap smear? ☐Yes ☐No If yes, _____An abnormal mammogram? ☐Yes ☐No If yes, _____
Breast discharge, masses or cancer? ☐Yes ☐No When was your last: Pap Smear _____Mammogram _____
Do you perform self-breast exams regularly? ☐Yes ☐No
Number of pregnancies? _____ Births? _____ Miscarriages? _____
Men:
Do you have difficulty with erections? ☐Yes ☐No
Would you like to discuss? ☐Yes ☐No
Musculoskeletal – Do you have or have you had:
Significant joint pain / arthritis? ☐Yes ☐No Gout? ☐Yes ☐No Neck pain?☐Yes ☐No
Back pain? ☐Yes ☐No Have you had a Bone Density Study? ☐Yes ☐No If yes, when? _____
Neurological – Do you have or have you had:
Tremors / shakes? ☐Yes ☐No Memory problems? ☐Yes ☐No Seizures? ☐Yes ☐No If yes, when?_____
A significant fall in the past year? ☐Yes ☐No Headaches? ☐Yes ☐No If yes, how often? _____
Numbness / tingling? ☐Yes ☐No If yes, where? _____Blackouts / fainting spells? ☐Yes ☐No
Mental / Emotional – Have you noticed:
In the past 2 weeks, have you felt down, depressed, or hopeless? ☐Yes ☐No
Have you recently had little interest or pleasure in daily activities? ☐Yes ☐No
Have you ever had depression so severe that you considered suicide? ☐Yes ☐No
Do you feel that you worry excessively? ☐Yes ☐No
Have you seen a psychiatrist/therapist in the past? ☐Yes ☐No If so, whom? _____
Hematologic/Lymphatic & Allergic / Immunologic – Have you had:
Anemia? ☐Yes ☐No Problems with your spleen? ☐Yes ☐No
Bleeding or clotting problems? ☐Yes ☐No Easy bruising? ☐Yes ☐No
Seasonal allergies/hay fever? ☐Yes ☐No If yes, what do you take? _____
Food, latex or drug allergies? ☐Yes ☐No If yes, what? _____
Have you seen an allergist? ☐Yes ☐No If yes, whom? _____
Do you have any other questions or concerns today? _____

Patient's Name: _____

Coleman Primary Care

Phone: 703-430-7090 | Fax: 703-444-9878 | 2 Pidgeon Hill Drive, Suite 400, Sterling, VA 20165

AUTHORIZATION TO DISCLOSE INFORMATION

Patient's Full Name _____

SS# _____

Date of Birth _____

INSTRUCTIONS FOR LEAVING MESSAGES
AND/OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION

OK to communicate with spouse? YES NO

Spouses Name _____

OK to leave information on answering machine? YES NO

OK to communicate with parent/children? YES NO

Name(s) _____

OK to communicate with caregiver? YES NO

Name _____

OK to communicate with any other person(s) YES NO

Please list _____

Communicate only with me YES NO

THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED IN WRITING

Signature _____

Date _____

Other Comments _____

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

I,_____, acknowledge receiving on
(print patient name)

_____ , a copy of Loudoun Medical Group's Notice of Privacy Practices.
(print date)

_____
Patient signature or initials

FOR OFFICE USE ONLY

I attempted to obtain the patient'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	Reason
		Refused to sign (circle if applicable) **Other:**

Phone: 703-430-7090 | Fax: 703-444-9878 | 2 Pidgeon Hill Drive, Suite 400, Sterling, VA 20165

INSURANCE WAIVER PRIVATE, COMMERCIAL AND MEDICARE INSURANCES

Medicare and or your private insurance carrier will only pay for services that it determines to be 'reasonable and customary" under Section 1862 (a) (1) of the Medicare law.

Medicare will not cover any routine physical or routine lab work. Medicare will only cover one well woman exam every two years.

It will be the patient's responsibility to verify that your insurance will cover any procedure that you are requesting to be done.

Private and commercial insurances will deny coverage for the following reasons:

A. Dr. Linda E. Coleman is not listed as the PCP
B. Patient is not listed as a covered dependent on said plan
C. Patient policy has terminated at time of service and/or patient did not present front desk with a current insurance card.
D. Patient went to a non-participating facility for any lab or tests, it is patient responsibility to verify correct lab and/or facility for tests
E. Insurance will only cover a limited amount toward a routine physical and/or labs
F. Routine physicals are only allowed every year or every other year depending on your insurance coverage
G. School, Sports and any other third party physicals are not a covered benefit under any insurance plan

If Medicare and/or my commercial insurance should deny any or all charges then I agree to be personally and fully responsible for any and all balances due.

Printed Name_____

Date of Birth_____

Signature_____

Today's Date_____

As your personal provider, my responsibilities are:

Explain diseases, treatment, and results in an easy-to-understand way. Listen to your feelings and questions which will help us make decisions about your care. Keep your treatments, discussions, and records confidential. Provide same day appointments whenever possible. Provide instructions on how to meet your health care needs when our office is not open through the answering service which provides 24-hour access to medical care. Give you clear directions about medicine and other treatments. Send you to a trusted specialist, if needed. End every visit making sure you have clear instructions about expectations, treatment goals, and future plans.

As our patient, your responsibilities are:

Asking questions, sharing your feelings, and taking an active part in your care. Being honest about your history, symptoms, and other important information, including any changes in your health and wellbeing. Taking all your medicine as directed. Inform us whenever there is a problem with the medication you are taking. Making healthy decisions about your daily habits and lifestyle. Keeping your scheduled appointments or reschedule in advance whenever possible. Calling our office first with your health concerns, unless it is an emergency. Being sure you leave our office with a clear understanding of our expectations, treatment goals and future plans.

As a patient in a medical home, I acknowledge my care is in collaboration with my primary care provider and the care team.

I agree to bring all information that pertains to my health created at another healthcare facility including, but not limited to:

- ☐ Ophthalmologic Testing (i.e., eye exams)
- ☐ Foot Exams
- ☐ Imaging Results
- ☐ Bloodwork
- ☐ Hospital Discharge Information
- ☐ Specialist Reports

Patient's Name DOB

Patient's Signature Date

Thank-You for Choosing Loudoun Medical Group.

The Mission of LMG is to provide compassionate, family-centered healthcare in a warm and friendly, hometown environment.

Loudoun Medical Group

224-D Cornwall Street NW, Suite 403
Leesburg, VA 20176

703.737.6010

Visits us online at:
www.lmgdoctors.com

Patient Centered *Medical Home*

LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Patient-Centered Medical Home

A Patient-Centered Medical Home (PCMH) is not a building, house, or hospital, but rather an approach to providing comprehensive health care.

A Medical Home is called a "Home" because we'd like this office to be the first place you think of for all your medical needs. Our goal is to make it easy and comfortable to get the care you need in a way that works best for you.

As your healthcare provider, we are here to facilitate a personal partnership with you and your family to provide you with the best quality, comprehensive, and progressive primary care.

Why are the Loudoun Medical Group Offices becoming PCMH's?

Our culture is one of continuous improvement with the result of providing high quality of care for all the patients we serve. We believe the Patient Centered Medical Home model will help us do this. By positioning your physician to provide, oversee, and coordinate all the care you need, the PCMH model seeks to strengthen the provider-patient relationship. It will replace episodic care based on symptoms and illnesses with coordinated, whole person care and long-term healing relationships. As our patient, you will enjoy an ongoing relationship with a personal provider. Your physician leads a team that takes collective responsibility for your care. The Medical Home also provides enhanced care through open scheduling, expanded hours, and fostering communication amongst patients, providers, and staff.

Joint Principles of the Patient-Centered Medical Home

Personal Provider – Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous, comprehensive care. In addition, your personal provider leads a team of individuals who collectively take responsibility for your ongoing care.

Whole Person Orientation – Your personal provider is responsible for providing all your health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care, chronic care, preventative services, and end of life care.

Care is coordinated or integrated – Your provider and healthcare team will coordinate your care with other elements of the health care system, such as subspecialty care, hospitals, home health agencies, and nursing homes. They are also equipped to integrate this care with your family and any public or private community services that you may currently use or that may be of benefit to you. Your Patient Centered Medical Home uses a vast array of information technology, registries, health information exchange, etc… to make sure you get the care you need when and where you need it.

Quality and Safety – By centralizing your care in one place, the potential for errors is minimized. Moreover, by putting the focus on you, our patient, the quality of care is enhanced.

Enhanced Access to Care – Open scheduling, expanded hours and new options for communication between patients, their personal provider and practice staff (e.g. webbased patient portal) makes it easier and quicker to get the care you need

The health and wellness of our patients is the #1 priority of this office. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, your provider, and you, my patient, work together. This is the basis behind the Patient-Centered Medical Home.

Coleman Primary Care

Phone: 703-430-7090 | Fax: 703-444-9878 | 2 Pidgeon Hill Drive, Suite 400, Sterling, VA 20165

OFFICE POLICY

WELCOME

We are pleased you have chosen us for your Primary Care needs. We are dedicated to giving you the best of care while providing you with support and explanations regarding your condition. We hope this will help answer questions you may have concerning our practice.

LOCATION

We are located on the 4th floor of 2 Pidgeon Hill Drive, Suite 400 in Sterling, VA 20165. Our phone number is 703-430-7090 and our fax number is 703-444-9878.

REFERRALS

It is the responsibility of the patient to know and understand their insurance policy. Some insurance policies require the member to obtain a referral from their primary care provider before being seen by a specialist. Referrals and prior authorizations can be obtained by calling our referral line at 703-444-9496. You will be asked to leave necessary information such as type of insurance, name of doctor you will be seeing, diagnosis and appointment date. If all pertinent information is not received your referral cannot be processed. Please allow 72 hours for referrals to be processed. If an office visit is needed before a referral can be issued you will be contacted by the receptionist to make an appointment.

APPOINTMENT AND OFFIE HOURS

Visits are by appointment only and can be scheduled by calling the receptionist at 703-430-7090 between the hours of 8:00 a.m. and 5:00 p.m. Monday through Thursday and 8:00 a.m. and 12:00 p.m. Friday. If you are unable to keep an appointment, you must call us at least 24 hours in advance or there will be a $75 no show fee charged to your account which is not billable to your insurance company.

We recognize the importance of prompt review and communication of test results to ensure accurate diagnoses, effective treatment, and optimal patient care. Your provider will determine when it is appropriate for you to schedule a follow-up visit to review any test results and/or manage your care. It is best to schedule your follow-up visit at check-out to ensure that your desired appointment time is available.

TELEPHONE CALLS

If you are concerned about your condition or have specific questions, please call the office. You will n e e d to provide the nursing staff with all necessary information and indicate the degree of urgency of the call. The nursing staff can answer most questions. In the event your specific question cannot be handled by one of the nurses, your message will be relayed to one of the practitioners. Rather than try to handle non-emergency calls immediately, it is our practice to return such calls at regular intervals during the day. Please allow 24 hours for calls to be answered.

PRESCRIPTIONS/REFILLS

All prescriptions and requests for refills should be requested during normal office hours by calling our prescription line at 703-444-9496 or by having your pharmacy fax us a refill request. Please have your pharmacy telephone number, prescription name and dosage close at hand. After hours prescriptions will not be refilled until the next business day.

FORM FEES

Forms needing to be filled out by a provider (i.e., school physical form, disability paperwork) are subject to a $10-$50 form fee which cannot be billed to your insurance company.

EMERGENCIES

In the event that an emergency occurs during office hours, call the office and you will be given instructions. If you feel your condition requires immediate medical attention go to the nearest emergency room or visit our Immediate Care Center at 46440 Benedict Drive, #107, Sterling, VA 20164. Their phone number is 703-450-1125.

BILLING AND COLLECTIONS

Payment for office visits, including co-pays, is expected at the time of service. Payment may be made by cash, check, Visa, MasterCard, or American Express. If we participate with your insurance we will file an insurance claim for your office visit. Inability to pay should be discussed prior to your visit so that acceptable payment arrangements can be made.

Our billing department can be reached at 703-737-6001, extension 6188. Before accounts are forwarded to a collection agency, we send multiple statements, as well as letters to the guarantor/policyholder, allowing ample time for payment arrangements to be discussed. If there is no response, this may result in your account being turned over to a collection agency.

NEW ADDRESS/INSURANCE INFORMATION

Please advise our staff of any new information, especially insurance updates, home addresses, and phone numbers so we may update our records. Having the same information as your insurance company is very critical. Claims submitted to an incorrect insurance provider may be denied due to timely filing issues and may become the patient's responsibility.

DISMISSAL FROM THE PRACTICE

Rarely, it is necessary to dismiss a patient from our practice. However, missing three scheduled appointments, not addressing billing issues, perpetually failing to follow treatment plans as advised, and abuse of the staff are all considered grounds for terminating our relationship.

RELEASE OF INFORMATION

Dr. Coleman's office may disclose any or part of the medical record to my insurance company (or companies) for purpose of satisfying charges billed. I further understand that it may be necessary to contact my past or present employer(s) in regard to the insurance claim. For further information please see the HIPAA release form.

TEST RESULTS POLICIES AND PROCEDURES

- Laboratory testing is an important part of a diagnostic evaluation. We encourage you to sign-up to our portal for an immediate access to your lab/diagnostic test results. However, if your test results are reviewed through portal and further question needed, you are required to make a follow-up appointment to your Dr.
- Critical values will result in a call from your provider so they can be discussed immediately.
- Please limit your calls for test results as they will not be reviewed over the telephone unless as stated above you are contacted by our office. All other questions should be addressed at a follow up appointment with your provider.

Any patient who would like to continue receiving a copy of his or her test results will need to leave a self-addressed stamped envelope at the front desk.

Coleman Primary Care

Phone: 703-430-7090 | Fax: 703-444-9878 | 2 Pidgeon Hill Drive, Suite 400, Sterling, VA 20165

RECEIPT OF OFFICE POLICY

I acknowledge receiving a copy of the Office Policy.

Print Patient Name	Date
Patient Signature	Date