1410 Rolkin Court Suite 201 | Charlottesville, VA, 22911
www.foxcareintegrativehealth.com
Tel: 434. 290. 1210 Fax: 434. 282. 2552

Please allow adequate time to complete as thoroughly as possible. All information is voluntary, confidential and for the sole purpose of evaluation and/or treatment assessment by certified and credentialed practitioners within FoxCare Integrative Health.

Office Use Only	
Received	
Scanned	
Appointment Date	

Please complete forms in black ink and return to:

Fax: (434) 282-2552 **Telephone:** (434) 290-1210
Mail: FoxCare Integrative Health
1410 Rolkin Ct #201, Charlottesville VA, 22911

PATIENT INFORMATION

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
SOCIAL SECURITY NUMBER	**SEX**	PREFIX/SUFFIX
DATE OF BIRTH *(mm/dd/yy)*	STATUS *(please check one)* □ Single □ Married □ Divorced □ Widowed □ Partner	STUDENT *(please check one)* □ No □ Full Time □ Part Time
STREET ADDRESS	**CITY/STATE**	**ZIP CODE**
HOME PHONE	CELL PHONE	WORK PHONE
EMAIL ADDRESS		
RACE *(please check one)* □ White □ Black/African American □ Asian □Hawaiian/Other Pacific Islander □ Other Race American □ Indian/Alaska Native	Ethnicity *(please check one)* □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown	Preferred Language *(please check one)* □ English □ Spanish □ Other: _________________
Preferred method of contact for appointment reminders *(please check one)* □Text Message □ Email □ Cell Phone □ Home Phone		
EMPLOYER	JOB TITLE/STATUS	EMPLOYER ADDRESS/PHONE NUMBER
How did you hear about us? (check all that apply) □ Online Search Engine □ Referred by friend □ Facebook/Social Media □ Referred by Physician: ___________________ □ Other: _____________________		

EMERGENCY CONTACT/GUARANTOR INFORMATION

CONTACT (please check at least one) □ Emergency Contact □ Next of Kin □ Authorized to Seek Treatment □ Guarantor	**LAST NAME**	**FIRST NAME**	MIDDLE INITIAL
SSN	**DATE OF BIRTH**	**SEX**	**RELATIONSHIP TO PATIENT**
HOME ADDRESS *(if different from above)*	**CITY/STATE**	**ZIP CODE**	**HOME/CELL PHONE**
EMPLOYER	WORK PHONE	JOB TITLE	

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Proud Member of Loudoun Medical Group

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

CONTACT (please check at least one) □ Emergency Contact □ Next of Kin □ Authorized to Seek Treatment ■ **Guarantor**	**LAST NAME**	**FIRST NAME**	**MIDDLE INITIAL**
SSN	**DATE OF BIRTH**	**SEX**	**RELATIONSHIP TO PATIENT**
HOME ADDRESS *(if different from above)*	**CITY/STATE**	**ZIP CODE**	**HOME/CELL PHONE**
EMPLOYER	WORK PHONE	JOB TITLE	

FoxCare Integrative Health collects payment at the time of service and will provide a reimbursement form to me at the time of service to submit to my insurance company. I understand that FoxCare may require a credit card deposit when I schedule an appointment. I also authorize FoxCare 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. _________ **Initial Here**

I acknowledge that Foxcare Integrative Health is a separate, non-affiliated entity from Foxygen Wellness and Sanavi Health and is not officially connected to them in any shape, form, or fashion. ________ **Initial Here**

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 § 32.1-45.1(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 B and 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.

____

Print Name

______________________________ ______________

Signature of Patient, Parent/Legal Guardian Date

____

Relationship to patient

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LOUDOUN MEDICAL GROUP
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.

____
Signature

____
Date

____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

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	Reason
		Refused to sign *(circle if applicable)* **Other:**

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__Please take your time to fill this form out completely__ 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. Please use black ink to complete this form.
Thank you.

Patient's Full Name: ____________________________________ Date of Birth: ________________________

Today's Date: _____________ Approx. Height: _________ Approx. Weight: __________ Age: __________

Primary Care Doctor: ____

Other physicians in your care team: ____

____

Reason for Visit: ____________________________ Preferred Pharmacy: ______________________________

Are you able to swallow pills? □ Yes □ No (Name, Street, City) _______________________________

__Allergies (List all medications, food and environment):__ □ No Allergies to Medications

Name	**Reaction that occurs:**

__Current Health Concerns (Please Rank current and ongoing health concerns in order of priority:__

Describe Problem	**Severity** (Mild, Moderate, Severe)	**Prior Treatment/Approach**	**Success** (Excellent, Good, Fair)
Example: Post Nasal Drip	***Mild***	***Elimination Diet***	***Excellent***
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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Prescription Medications: □ No Medications

Date Started	Medication & Dose	Directions	Reason for Taking	Prescribed By:

Supplements: □ No Supplements

Date Started	Supplement & Dose	Directions	Reason for Taking	Prescribed By:

Have medications or supplements ever caused unusual side effects or problems? □ Yes □ No
If yes, describe: ____

____

Have you ever use any of these regularly or for a long time:

NSAIDS (Advile, Aleve, etc.), Motrin, Aspirin? □ Yes □ No
Tylenol (acetaminophen)? □ Yes □ No
Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? □ Yes □ No

How many times have you taken antibiotics? ____

Have you ever taken long term antibiotics? □ Yes □ No If yes, explain: ________________________

How often have you taken oral steroids (e.g. cortisone, prednisone, etc.)? ________________________

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Medical History:

Past Medical History: (Please check all that apply)

□ Digestive Issues (e.g. reflux, celiac, IBS, etc.)	□ Constipation	□ Asthma	□ Diabetes	□ Hypothyroidism (low thyroid)
□ Hyperthyroidism (overactive thyroid)	□ Eating disorder	□ Chronic fatigue syndrome	□ Allergies	□ Multiple chemical sensitivities
□ POTS	□ PANS/PANDAS	□ Lyme Disease/Co-infections	□ Chronic pain	□ ADHD
□ Autism	□ Cancer Type: ____________	□ Epilepsy/Seizures	□ Immune deficiency	□ Eczema

Please list any other past medical history: ____
____
____

Past Surgical History: □ No Surgeries

Surgery	*Date*	*Surgery*	*Date*	*Surgery*	*Date*
Appendectomy		Dental		Gallbladder	
Hernia		Tonsillectomy		Adenoids	
Heart surgery		Ear Tubes		Colonoscopy	
Wisdom Teeth		Other:			

Past Hospitalizations? □ None Dates and Reason: ____
____

Injuries	**Date**	**Comments**
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		

Diagnostic Studies	**Date**	**Comments**
CT scan		
EKG		
MRI		
X-Ray		
Other:		

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Lifestyle Review:

Sleep:

How many hours of sleep do you get each night on average? ________________________________

On a typical night: What time is Lights out? ________________ Wake up time? _________________

Do you have problems falling asleep? □ Yes □ No   Problems staying asleep? □ Yes □ No

Do you have problems with insomnia? □ Yes □ No   Do you snore? □ Yes □ No

Are you an active sleeper? (kicking or turning in sleep) □ Yes □ No

Do you feel rested upon awakening? □ Yes □ No

Do you use sleeping aids or medications? □ Yes □ No

If yes, explain: ____

Exercise:

Current Exercise/Activities (duration and number of times per week?):

____

____

____

Do you feel motivated to exercise? □ Yes □ A Little □ No

Are there any problems that limit exercise? □ Yes □ No

If yes, explain: ____

Do you feel unusually fatigued or sore after exercise? □ Yes □ No

If yes, explain: ____

Diet:

Please record what you eat in a typical day:

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Fluids ____

How many servings do you eat in a typical week of these foods?

Fruits (not juice) ______   Vegetables (not including white potatoes) ________

Legumes (beans, peas, etc.) ______   Red Meat _______   Fish _________

Dairy/Alternatives _______   Nutes & Seeds _______   Fats & Oils _______

Cans of soda (regular or diet) ________   Sweets (candy, cookies, cake, ice cream, etc.) ______

Do you drink caffeinated beverages? □ Yes □ No

If yes, what kind and how many cups? ____

Do you have adverse reactions to caffeine? □ Yes □ No

If yes, explain: ____

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Nutrition:

Do you currently follow any of the following special diets or nutritional programs? (*Check all that apply)*

□ Vegetarian □ Vegan □ Allergy □ Elimination □ Low Fat □ Low Carb □ High Protein
□ Auto-Immune Paleo □ Blood Type □ Low sodium □ No Dairy □ No Wheat □ Gluten Free
□ No Soy □ Reduced Sugar □ Ketogenic
□ Other: ____

Do you have sensitivities to certain foods? □ Yes □ No
If yes, list foods and symptoms: ____

Do you have an aversion to certain foods? □ Yes □ No
If yes, explain: ____

Do you adversely react to: *(check all that apply)*

□ Monosodium glutamate (MSG) □ Artificial Sweeteners □ Garlic/onion □ Cheese
□ Citrus foods □ Chocolate □ Alcohol □ Red wine □ Food coloring
□ Sulfite-containing foods (wine, dried fruit, salad bars) □ Preservatices □ Fermented foods
□ Other: ____

Are there any foods that you crave or binge on? □ Yes □ No
If yes, what foods?: ____

Do you eat 3 meals a day? □ Yes □ No If no, how many ______________________________

Does skipping a meal greatly affect you? □ Yes □ No

How many meals do you eat out per week? □ 0-1 □ 2-3 □ 4-5 □ >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

□ Fast eater
□ Eat too much
□ Late-night eating
□ Dislike healthy foods
□ Time constraints
□ Travel frequently
□ Eat more than 50% of meals away from home
□ Healthy foods not readily available
□ Poor snack choices
□ Significant other or family members have special dietary needs
□ Don't care to cook
□ Confused about nutrition advice
□ Love to eat
□ Eat because I have to
□ Have negative relationship to food
□ Struggle with eating issues
□ Emotional eater (eat when sad, lonely, bored, etc.)
□ Eat too much under stress
□ Eat too little under stress
□ Significant other or family members don't like healthy foods

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Stress:

Do you feel you have an excessive amount of stress in your life? □ Yes □ No

Do you feel you can easily handle the stress in your life? □ Yes □ No

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work/School _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you use relaxation techniques? □ Yes □ No

If yes, how often? ______________________________

What techniques do you use? *(Check all that apply)*

□ Meditation □ Breathing □ Tai Chi □ Yoga □ Prayer □ Other: ______________

Have you ever sought counseling? □ Yes □ No

Are you currently in therapy? □ Yes □ No

If yes, describe: ______________________________

Have you ever been abused, a victim of crime, or experienced a significant trauma? □ Yes □ No

What are your hobbies or leisure activities? ______________________________

Relationships:

With whom do you live? (include children, parents, siblings, relatives, friends, pets) ______________

____

____

Current occupation: ______________________________

Previous occupations: ______________________________

Do you have resources for emotional support? □ Yes □ No *(Check all that apply)*

□ Partner □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: ______________

Do you have a religious or spiritual practice? □ Yes □ No

If yes, what kind? ______________________________

How well have things been going for you? *(Mark on scale of 1-10, or N/A if not applicable)*

	N/A	Poorly				Fine					Very Well
Overall	□	1	2	3	4	5	6	7	8	9	10
At school	□	1	2	3	4	5	6	7	8	9	10
In your job	□	1	2	3	4	5	6	7	8	9	10
In your social life	□	1	2	3	4	5	6	7	8	9	10
With close friends	□	1	2	3	4	5	6	7	8	9	10
With your attitude	□	1	2	3	4	5	6	7	8	9	10
With your parents	□	1	2	3	4	5	6	7	8	9	10
With your siblings	□	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	□	1	2	3	4	5	6	7	8	9	10

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History:

Patient's Birth/ Childhood history:

You were born: □ Term □ Premature □ Don't know

You were born: □ Vaginal □ C-section If C-section, why? ______________________

Were there any pregnancy or birth complications? □ Yes □ No

If yes, explain: ____

You were: □ Breast-fed/How long? ____________ □ Bottle-fed/ Type of formula: _________________

Age of introduction of: Solid food: __________ Wheat ________ Dairy ________

As a child, were there any foods that were avoided because they gave you symptoms? □ Yes □ No

If yes, what foods and what symptoms? (Example: milk – gas and diarrhea)

____

____

Did you eat a lot of sugar or candy as a child? □ Yes □ No

Dental History:

Check if you have any of the following, and provide number if applicable:

□ Silver mercury fillings _____ □ Gold fillings _____ □ Composite fillings _____ □ Root canals _____

□ Implants _____ □ Tooth pain _____ □ Bleeding gums _____ □ Gingivitis _____

□ Problems with chewing _____ □ Other dental concerns (explain): _____

Have you had any mercury fillings removed? □ Yes □ No If yes, when: ___________________

How many fillings in total have you had? ____________________

Do you brush regularly? □ Yes □ No Do you floss regularly? □ Yes □ No

Do you regularly receive dental care/cleaning? □ Yes □ No

Menstrual History: (Females only)

Have you had your first period? □ Yes □ No

If yes, age at first period ________ Date of last menstrual period __________

Length of cycle ___________________ Time between cycles _________________________

Cramping? □ Yes □ No Pain? □ Yes □ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? □ Yes □ No

If yes, please describe ____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? □ Yes □ No

If yes, please describe ____

Do any of your medical conditions increase in severity around your period? □ Yes □ No

If yes, please describe ____

Use of hormonal birth control: □ Yes □ No

If yes, please describe ____

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Environmental/Detoxification History:

QUESTIONS – mark 1 point for each answer, total at the bottom	**YES**	**NO**
Diet		
Do you consume conventionally grown (non-organic) fruits or vegetables regularly? If so, which ones do you eat most often? ____________________________________		
Do you consume conventionally raised animal products (meat, dairy, eggs) regularly? If so, which ones do you eat most often? _____________________________________		
Do you consumer, fish or seafood more than twice a week? If so, please describe what you eat and whether it is farmed or wild. _____________________________________		
Do you consume fast foods, canned/packaged foods, soda, or foods with artificial colors, flavors, preservatives or sweeteners more than three times a week?		
Do you drink water from a well, spring or cistern, or from plumbing pipes or fixtures installed before 1986?		
Living/School/Work Environment		
Are you often exposed to adhesives, paints, flea treatments, varnishes, solvents, welding/soldering materials, or other air-borne chemicals?		
Have you lived in a mobile home, boat or TV, or a very old or brand new home? If so, please describe: ____		
Does your home or school have visible mold, water damage, damp windows, or basement/crawlspaces? Or had to be remediated for mold at any point?		
Does your home or workplace have cracking paint or decaying insulation or foam?		
Do you regularly use conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or school?		
Have you ever been exposed to known heavy metals including mercury (e.g. broken mercury thermometers) or lead (lead paint or dust)?		
Are you frequently exposed to pesticides, fungicides or insecticides such as at farmland, parks and golf courses or at your home/school?		
Do you live near a cell phone tower/power lines or feel poorly when around these including WiFi?		
Others		
Do you smoke or are often exposed to second-hand smoke?		
Are you highly sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?		
Have you had root canals, tooth extractions, “silver” fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, gental implants, etc?		
Have you had any unusual reactions to anesthesia or to prescription or over-the-counter medications? If so, please describe: ____		
Do you have any pets or farm animals? If yes, are they inside or outside? ____________________		
Total		

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Family History:

Check family members that have/had any of the following:

	Mother	Father	Brother(s)	Sister(s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)									
Age at death (if deceased)									
Cancer									
Heart disease									
Hypertension									
Obesity									
Diabetes									
Stroke									
Autoimmune diseases									
Arthritis									
Kidney disease									
Thyroid problems									
Seizures/epilepsy									
Psychiatric disorders									
Schizophrenia/Bipolar Disorder									
Anxiety									
Depression									
Asthma									
Allergies									
Eczema									
ADHD									
Autism									
Irritable Bowel Syndrome									
Dementia									
Substance abuse									
Genetic disorders									
Other: ___________________________________									

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Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health how willing are you to:

Significantly modify your diet	□ 5	□ 4	□ 3	□ 2	□ 1
Take several nutritional supplements each day	□ 5	□ 4	□ 3	□ 2	□ 1
Keep a record of everything you eat each day	□ 5	□ 4	□ 3	□ 2	□ 1
Modify your lifestyle (e.g. work demands, sleep habits)	□ 5	□ 4	□ 3	□ 2	□ 1
Practice a relaxation technique	□ 5	□ 4	□ 3	□ 2	□ 1
Engage in regular exercise	□ 5	□ 4	□ 3	□ 2	□ 1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities?	□ 5	□ 4	□ 3	□ 2	□ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? ____

____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive)

At the present time, how supportive do you think the people in your household will be to implementing the above changes?	□ 5	□ 4	□ 3	□ 2	□ 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?	□ 5	□ 4	□ 3	□ 2	□ 1

Comments ____

____

____

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Health Goals

What do you hope to achieve in your visit with us? ____

____

____

____

When was the last time you felt well? ____

____

____

____

Did something trigger your change in health? ____

____

____

____

What makes you feel better? ____

____

____

____

What makes you feel worse? ____

____

____

____

How does your condition affect you? ____

____

____

____

What do you think is happening and why? ____

____

____

____

What do you feel needs to happen for you to get better? _____________________________________

____

____

____

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Symptom Review Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Difficulty staying asleep	☐	☐	☐
Fatigue	☐	☐	☐
Frequent Fever	☐	☐	☐
Heat Intolerance	☐	☐	☐
Nightmares	☐	☐	☐
Head, Eyes, and Ears			
Frequent conjunctivitis	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscles twitches:	☐	☐	☐
Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐
Muscle weakness	☐	☐	☐
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Social anxiety	☐	☐	☐
Separation anxiety	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty:	☐	☐	☐
Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness/ Light-headedness	☐	☐	☐
Emotional lability/rollercoaster	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Hallucinations:	☐	☐	☐
Auditory	☐	☐	☐
Visual	☐	☐	☐
Irritability	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart murmur	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender lymph nodes	☐	☐	☐

Skin Problems			
Acne on back/chest/shoulders	☐	☐	☐
Acne on face	☐	☐	☐
Athlete’s foot	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Dark circles under eyes	☐	☐	☐
Dry hair	☐	☐	☐
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Hives (frequent)	☐	☐	☐
Patchy dullness	☐	☐	☐
Rashes	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy/oak	☐	☐	☐
Itching Skin	☐	☐	☐
Where? ___________________________________			
Urinary			
Bed wetting	☐	☐	☐
Daytime accidents	☐	☐	☐
Infection	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Urgency	☐	☐	☐
Digestion			
Dental cavities	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating:	☐	☐	☐
Lower abdomen	☐	☐	☐
Whole abdomen	☐	☐	☐
After meals	☐	☐	☐
Blood in stools	☐	☐	☐
Excessive burping	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipations	☐	☐	☐
Diarrhea	☐	☐	☐
Farting	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Heartburn	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Mucus in stools	☐	☐	☐
Nausea	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Vomiting	☐	☐	☐
Lower abdominal pain	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can’t gain weight	☐	☐	☐
Can’t lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Picky eater	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Unexplained weight loss	☐	☐	☐
Unexplained weight gain	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Cough	☐	☐	☐
Dry	☐	☐	☐
Productive	☐	☐	☐
Hayfever:	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infections	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter stuffiness	☐	☐	☐

LOUDOUN MEDICAL GROUP PC
NOTICE OF PATIENT PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

Who Does this Notice Apply to?

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from **May 20, 2013** until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment***. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
  These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment***. We may use or disclose information about you for payment purposes to our clerks and officers

involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in connection with payment for your care.

- ***Health care operations***. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- Unless you object, to friends or family members who are involved in your medical care.
- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appoint-ments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

<u>What Legal Rights Do You Have In Connection With Your Information?</u>

- <u>Right to Inspect and Copy</u>. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the information, there will be a charge based on our costs.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- <u>Right to Amend</u>. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- Is not part of the medical information kept by or for LMG;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.