



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.

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

Office Use Only	
Received	
Scanned	
Appointment Date	

PATIENT INFORMATION

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

EMERGENCY CONTACT/GUARANTOR INFORMATION

CONTACT (please check at least one) <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Next of Kin <input type="checkbox"/> Authorized to Seek Treatment <input type="checkbox"/> 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		



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

CONTACT (please check at least one) <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Next of Kin <input type="checkbox"/> Authorized to Seek Treatment <input checked="" type="checkbox"/> 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 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 <i>(circle if applicable)</i> Other:

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 appointments. *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.

What Legal Rights Do You Have In Connection With Your Information?

- **Right to Inspect and Copy.** 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.

- **Right to Amend.** 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.