Virginia Women's Health Associates
Obstetrics and Gynecology
Medical History Data Base

Date:_____ Name:_____ Date of Birth/Age:_____
Reason for being seen today:_____

1. ALLERGIES
Please list any drug allergies and their reactions:

Drug	Reaction	Drug	Reaction

2. MEDICATIONS
Please list any medications and the dosages that you are now taking:

Drug	Dosage	Drug	Dosage

3. MEDICAL HISTORY
Please check all that apply:

Are you under a doctor's care □ Yes □ No

High Blood Pressure	□	Urine Infections	□	Epilepsy	□
Diabetes Mellitus	□	Gallbladder Disease	□	Hepatitis	□
Pneumonia	□	Migraine Headaches	□	AIDS/HIV	□
Rheumatic Fever	□	Thyroid Problems	□	Asthma	□
Tuberculosis	□	Thormbophletitis	□	Cancer	□
Pulmonary Embolism	□	Heart Problems/Murmur	□	Anxiety	□
Depression	□	ADD/ADHD	□		

Other (*please specify*) :_____

	Date	Results		
Last Pap Smear		□ Normal	□ Abnormal	
Last Dexa Scan (Bone Density)		□ Normal	□ Osteopenia	□ Osteoporosis
Colonoscopy		□ Normal	□ Abnormal	

Do you examine your breasts regularly?	□ Yes	□ No	Date of last mammogram:
Have you ever had a mammogram?	□ Yes	□ No	

4. SURGICAL HISTORY

Operation	Year	Location	Findings/complications/transfusions:

5. SOCIAL FACTORS	Yes	No	
Tobacco Use	□	□	Occupation:_____
Alcohol Use	□	□	Marital Status:_____
Street/Recreational Drugs	□	□	Exercise Program:_____
			Faith/Religious Preference:_____

6. FAMILY HISTORY

Please list any illnesses that your parents, siblings, children, or grandparents have:

Illness	Mother	Father	Sibling	Child	MGF (Maternal Grandfather)	MGM (Maternal Grandmother)	PGM (Paternal Grandmother)	PGF (Paternal Grandfather)
High Blood Pressure								
Heart Attack								
Diabetes Mellitus								
Cancer (please specify)								
Breast Cancer								
Twins								
Other								

7. GYNECOLOGICAL HISTORY

Menarche (age of first period):_____ Last normal menstrual period (LMP):_____

Frequency (Number of days between periods):_____ Duration:_____

Amount: □ Light □ Moderate □ Heavy

Dysmenorrhea (Menstrual pains): □ Yes □ No Abnormal bleeding: □ Yes □ No

Sexually active: □ Yes □ No □ Never Active with: □ Male □ Female □ Both

Any history of abuse:_____

Have you ever had any of the following?

Genital Warts/HPV	□	Tubal Infections (PID)		□	B-Streptococcus		□	
Cone Biopsy	□	Cryosurgery (Freezing)		□	Cautery		□	
Laser Surgery	□	Gonnorrhea		□	DES Exposure		□	
Chlamydia	□	Endometriosis		□	Syphilis		□	
Abnormal Discharge	□	AIDS		□	Ovarian Cysts		□	
Trichomonas	□	Abnormal Pap Smear		□	Gardnerella		□	
Colposcopy	□	Herpes		□	D&C		□	

Other:_____

8. OBSTETRICAL HISTORY (*please include all pregnancies and abortions)*

Type of Delivery	Year	Name	Sex	Weight	# Weeks Pregnant	Complications

10. FAMILY PLANNING HISTORY

Method	Date	Complications
Natural Family Planning		
Birth Control Pills		
Diaphragm, foam, jelly, cream		
Depo Injections		
Patch		
Vaginal Ring		
Intrauterine Device (IUD)		
Condoms		
Tubal ligation, Vasectomy		

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Virginia Women's Health Associates
Obstetrics, Gynecology, Infertility

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	CELL PHONE
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	
PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS *(please circle one)* Text Message Email Cell Phone Home Phone		
REFERRED BY:		

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	

Over

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)*		HOME PHONE

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.

Any appointments that are not cancelled 24 hours in advance will be charged a no-show fee of no less than $50.00. The fee will be determined based on the appointment type.

_____ _____

Print Name **Date**

_____

Signature

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

_____ _____

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

_____

Relationship (if signature is not of Patient)
Signature of Person Obtaining Consent

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:**

Virginia Women's Health Associates
Obstetrics, Gynecology, Infertility

Patient Communication Preferences, HIPAA Privacy Rule, & Consent

In a continued effort to better serve our patients, we have developed a new communications process and ask that you indicate your preferences below. These preferences will be used for automated *appointment confirmations, normal lab result notifications, health maintenance reminders, inclement weather alerts, and other notifications.*

Please select only **ONE** option

↙ **or** ↘

☐ Please **TEXT MESSAGE** me with all notifications.
Preferred Phone Number: _____

☐ Please **CALL** me with all notifications.
Preferred Phone Number: _____

NOTE**:** The HIPAA Privacy Rule permits providers to communicate with patients regarding their health care via mail and phone. Additionally, the HIPAA Privacy Rule allows providers to leave messages for patients on their answering machines regarding their healthcare. If you do **NOT** wish to receive any voice messages with private health information, please indicate that below.

☐ **I DO NOT** want VWHA to leave voice messages – affiliated with the phone number(s) I have provided the practice – with private health information, to include lab results.

Email Address: _____
(To be used with Patient Portal - **coming soon**)

As the patient, I am in understanding that should my telephone number(s) change, it is my responsibility to update contact information with my doctor's office (VWHA).

Patient Signature: _____

Patient Printed Name: _____

Date: _____

PROUD MEMBER OF LMG LOUDOUN MEDICAL GROUP
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Virginia Women's Health Associates
Obstetrics, Gynecology, Infertility

Camilla C. Hersh, M.D. Grace Artrip, WHNP
Mary Jo Frickel, CFNP

PERSONAL HEALTH INFORMATION AUTHORIZATION FORM

Patient Name: _____ **DOB:** _____

I, _____, give permission to Virginia Women's Health Associates (VWHA) to use or disclose my personal health information to the following person(s):

Name: _____

Relationship to Patient: _____

☐ _____**By signing here, I authorize *ANY AND/OR ALL* of my personal health information to be shared with the individual(s) listed above.**

☐ _____**By signing here, I authorize my personal health information to be shared with the individual(s) listed above *with the following LIMITATIONS AND/OR SPECIAL INSTRUCTIONS*:** _____
_____

By signing below, I certify that I have read and understand authorization to Virginia Women's Health staff to share all/limited personal health information to the above individual(s). Furthermore, I understand that I may revoke this authorization at any time by asking to complete a revocation form that VWHA will provide me upon request. I understand that such revocation will become effective on the date I complete the request form and will have no effect on the uses and/or disclosures made prior to that date. THIS AUTHORIZATION WILL EXPIRE ONLY AFTER I COMPLETE A REVOCATION FORM

I acknowledge that I have had an opportunity to read and understand the contents of this authorization form and my signature confirms that this authorization form accurately reflects my wishes

Patient Signature: _____ **Date:** _____

1800 Town Center Drive | Suite 220 | Reston, VA 20190
Office: 703-435-2555 | Fax: 571-926-8910

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LOUDOUN MEDICAL GROUP PC

CONSENT TO PARTICIPATE IN TELEMEDICINE

Patient Name: _____ Date of Birth: _____

Physician Name: _____ Facility Name: **Virginia Women's Health Assoc**

I understand that telemedicine is the use of electronic information and communication technology by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand my health care provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter. I understand I can choose to stop telemedicine consult at any time.

I understand that:

- My health care professional and I will communicate by interactive video conferencing using a telehealth platform.
- My health care professional will have access to all the clinical tools available at a regular office visit. (e.g. prescription refills, appointment scheduling, patient education etc.)
- The Telehealth platform may ask for vital signs. I understand I will enter height in feet and inches, weight in pounds, blood pressure, temperature, and pulse rate.
- There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- My healthcare information may be shared with other individuals for scheduling and billing purposes.
- The laws that protect privacy and the confidentiality of medical information also applies to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date

Updated: 03/14/2023

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.

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.