Mountcastle
Plastic Surgery & Vein Institute

Name DOB:____/_____/_____

Address

Home Phone _____ Cell Phone _____

Social Security #_____ Email Address:_____

Preferred Pharmacy Name, Address and Phone number?

Insurance Policy Holder Information

Primary Insurance:_____ **Secondary Insurance:**_____

Name:_____ DOB: _____ Name:_____ DOB: _____

Social Security #
Phone Number: _____
Relationship to Policy Holder _____

Social Security #
Phone Number: _____

For what problem are you seeking care for today? _____
First noticed when?_____ Location _____(R / L)
Severity / Size _____ Recent changes _____

Who referred you to the practice? _____

Who is your Primary Care Physician? _____

Medicines: (Dosage and how often)	Allergies to medicines:
_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ Are you allergic to betadine? Yes / No Or Latex? Yes / No

Do you smoke? (How much)_____ Alcohol _____Drugs_____

Past Surgeries:	

List number of pregnancies (if applicable):_____ Date of last mammogram:_____

Medical Problems you have (please **Circle** all that apply)

Arthritis	Diabetes	Kidney Problems	HIV/AIDS
Heart Problems	Asthma	Heart attack	Skin Disorders
Hepatitis	Stroke	TB	Anemia
Leg Ulcers	Gastric Reflux	Stomach Ulcer	High Blood Pressure
Depression	Anxiety	Bleeding Problem	High Cholesterol
Lung Problems	Hernia	Emphysema	Thyroid Disease
Clotting Problem/DVT		Cancer :(type) _____	

Review of Systems: Have you recently had any of the following? (**Circle** all applicable)

General:	Weight Loss or gain Vision changes	Cold or Flu Fainting	Fever Weakness on one side	Night sweats Seizures
Respiratory:	Trouble breathing	Awaking short of breath	Persistent cough	Short of breath while lying
Heart:	Chest pain	Arrhythmias	Heart attack	
GI:	Indigestion Blood in stool	Vomiting Constipation	Diarrhea	Abdominal pain
Urology:	Trouble passing urine	Peeing frequently	Peeing with great urgency	Pain urinating
Musculoskeletal:	Swelling of lymph glands	Back trouble	Arthritis	Muscle pain
Skin:	Skin trouble	Rash	Skin cancer	Open wound
Psychological:	Depression	Anxiety		
Vascular:	Varicose veins	Leg Cramping	Blood clots in legs	Leg pain
	Restless legs	Feet/Leg Swelling	Leg cramps	Ulcers
Endocrine:	Excessive thirst or urination	Feeling too hot / cold	Thyroid problems	

Family History: Circle any medical problems that run in your family.

Diabetes Bleeding/Clotting issues Cancer (what type)_____
Heart disease Stroke High blood pressure Varicose Veins Other:_____

Venous History (Legs): Circle any symptoms that apply.

Pain Aching Heaviness Burning Itching Bleeding
Redness Swelling Ulceration Skin discoloration Other:_____

What makes your symptoms better?_____
What makes your symptoms worse?_____
Have you ever been treated for varicose/spider veins?_____
If so, what type of treatment?_____

PATIENT AUTHORIZATION

Initial each paragraph below:

_____ *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. I understand that my health insurance company may deny payment for services. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.
This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third party service acting for LMG, PC, or any of its affiliates.

_____ *I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medial office within a reasonable amount of time.

_____ *I understand that if surgery is warranted, the guidelines set by the hospital and anesthesia departments require patients be seen within 30 days of their surgery date. If surgery is scheduled outside of 30 days from an office appointment, I understand I will be required to return to the office for an additional evaluation. Standard charges and copayments will apply.

_____ *I 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

_____ *I hereby authorize the release of medical information via fax as may be deemed necessary by my physician, with regard to my medical care.

*I agree to allow you to speak to the following family members or acquaintances about my medical care. You may correspond with them either in person, via phone, email or mail.

_____

_____

_____

Loudoun Medical Group Receipt of Notice of privacy practices acknowledgment:

*I, _____, acknowledge receiving on the below date, a copy of Loudoun medical group's notice of privacy practices.

Patient written name

Signature _____ Date _____
Patient/Parent/Authorized Agent or Representative

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Appointment and Cancellation Policy

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

1. **Cancellation of an Appointment**

If it is necessary to cancel or reschedule your scheduled appointment we require that you call by 10 a.m. two (2) working days in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel or reschedule appointments please call 703-858-3208. If you do not reach the receptionist please leave a detailed message on the voice mail.

2. **No Show Policy**

A "no show" is someone who misses an appointment without canceling it by 10 a.m. two (2) working days in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". The following fees apply for patients who "no show":

Non-Cosmetic Office Surgeries/Consultations $30.00

Cosmetic Consultations $150.00

Vein Procedures $150.00

Ultrasounds $150.00

The patient will be sent a bill alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment by 10 a.m. two (2) working days in advance. The bill is expected to be paid in a timely manner or it is subject to interest.

I have read and understood Mountcastle Plastic Surgery's appointment and cancellation policy. I agree to the "no show" charges I may be responsible for.

Patient Signature:_____Date:_____

Witness:_____