Welcome to:

Tysons Internal Medicine & Labelle MD Esthetics

If you are unable to keep your appointment, please let us know within:

24 hours in advance for medical and **48 hours** in advance for cosmetic patients.
Otherwise, you will be responsible for a cancellation fee of:

$50.00 for medical appointment

$150.00 for cosmetic appointment

Office requires all pending balances to be clear at the time of your visit.

Patient's signature: ____

Date ____

Medical Information Release Form (HIPAA Release Form)

Patient's Name: ____
Date of Birth: ____

Release of Information

I authorize the release of information including the diagnosis, records, examination results, medication dose changes, and claims information.
This information may be released to:

- ☐ Spouse____
- ☐ Child(ren)____
- ☐ Other____
- ☐ Information is not to be released to anyone other than me.

Messages

Please call ☐ my home phone is___________ ☐ my cell phone is ____________
If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Do not leave messages on my phone mailbox.

The best time to reach me is (day of week) ________between (time)__________

E-mail Messages

- ☐ Use my e-mail address to send messages for me to contact the nurse for information
- ☐ Use my e-mail to leave detailed messages and information.
- ☐ Attach lab results to the e-mail message.

My e-mail address is____

This Release of Information will remain in effect until terminated by me in writing. This release specifically excludes any psychiatry and psychology evaluations / records which are further restricted by HIPAA regulations.

Patient's Signature: ____

Date: ____

Tysons Internal Medicine

FINANCIAL POLICIES, EFFECTIVE 12/01/24

Private Pay: If you do not have insurance, payment will be due at the time of service. We require a minimum of 100% of the balance paid at the time of service.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that Dr. Lorena Popp participates in your specific plan. If Dr. Lorena Popp is not a participating provider for your plan, you may still select our office for your medical care: "out of network" benefits will apply. It is also your responsibility to know your insurance benefits. Our office will not advise you of your benefits. Please contact your insurance company at the Customer Service phone number printed on your insurance card if you have questions pertaining to coverage.

As a courtesy to our patients, we file claims with your insurance on your behalf. To do this, we require all information to be completed on the Patient Registration Form. You will be asked to show your insurance card at each visit.

You are responsible for paying all co-pays at the time of service. Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office, as it is a requirement placed on your insurance carrier.

Billing: If you receive an invoice from our office for balance dues, it is because that is the balance your insurance policy requires you to pay. Please contact your insurance company first if you have questions about that.

A “NO SHOW FEE” OF $50.00 WILL BE CHARGED, IF YOUR APPOINTMENT IS NOT CANCELLED 48 HOURS IN ADVANCE.

We require a credit card on file to pay for co-pays, missed appointment fees, and any balance reported as patient responsibility. You will be notified of any charges equal to or more than $100.00.

PATIENT NAME (ON CARD): ____
CREDIT CARD #____
EXPIRATION DATE ____
CVV CODE: ____

BY PROVIDING A CREDIT CARD ON FILE, YOU ARE AUTHORIZING TYSONS INTERNAL MEDICINE TO CHARGE YOUR CREDIT CARD FOR ANY MISSED APPOINTMENT FEE OR BALANCE ON YOUR FILE.

Tysons Internal Medicine and Wellness Center

PATIENT INFORMATION

First Name: _________________ Last Name: ___________________ Sex: ☐M ☐F
Address: _______________________________ City ___________ State___ Zip_____
Home phone: _________________ Cell phone: ______________________________
Email Address: ____
DOB: Month _________ Day __ Year _____ Race _______ Marital Status _______
Employer __________________________ Address ____________________________
Phone ________________ Occupation ________________Education _____________

EMERGENCY CONTACT

First Name: _____________________ Last Name: ___________________________
Relationship to patient __________________ Phone Number __________________

INSURANCE INFORMATION

Insurance Name: ________________________ Policy Holder: __________________
Member ID: _____________________________Group Number: _________________

PREFERRED PHARMACY

Name: __________________________________ Phone: _______________________
Address: ____

1. Tysons Internal Medicine and Wellness Center does not guarantee insurance coverage as payment.
2. If your insurance company does not settle your claim within 90 days of claim submission, you will be billed for the services.
3. All non-covered services need to be paid at the time of the visit.
4. All co-payments need to be paid at the time of the visit.
5. There will be a $50 charge for any missed appointment without cancellation notice.

Signature______________________________ Date ____________________________

SOCIAL HISTORY

Marital Status_____________ Children_________Occupation__________________
Smoking Status:
☐ Never smoked ☐ Now smoking ☐ Used to smoke ☐ Chew Tobacco
If smoking ___________cigarettes ___________ packs per day/week (circle)
Drinking status:
Alcohol type______________Amount___________________per day/week (circle)
Street drugs including marijuana, cocaine, heroin and other mood-altering drugs or pills____
Guns in the home? ☐ Yes ☐ No
Caffeinated beverages (coffee, tea. soda. etc.)________________________________
Do you consistently wear seatbelts? ☐ Y☐ N
Sexual orientation:
☐ Heterosexual ☐ Homosexual ☐ Bisexual☐ Other
Do you eat well? ____
How do you feel about your weight? _______________________________________
Exercise type_________________________ How often? _________________________
Are you an organ donor? ☐ Yes ☐ No
Do you have a living will? ☐ Yes ☐ No

FEMALES ONLY:

Menstruation:
Age of onset_______ Flow ☐Regular ☐Irregular☐Heavy ☐Moderate☐Light
Number of pregnancies _____________ Last Pap Smear ☐ Normal☐ Abnormal
Number of live births _____________ Last Mammogram☐Normal☐ Abnormal
Number of abortions_______________ Number of ectopic pregnancies __________
Number of miscarriages ______________ Age at first pregnancy_______________
Are you currently pregnant?☐ Yes☐ No Are you breastfeeding?☐ Yes ☐ No
Any post-menopausal vaginal bleeding? ☐ Yes ☐No

MALES ONLY:

Do you practice testicular self- exam? ☐ Yes ☐No
Do you have urinary frequency? ☐ Yes ☐ No
Is there a history of impotence? ☐Yes ☐ No
Do you have a urethral (penile) discharge? ☐Yes ☐No
Do you wake up at night to urinate?☐ Yes☐ No
Do you regularly use condoms? ☐Yes ☐ No

HEIGHT______________________________WEIGHT_________________________

PAST MEDICAL HISTORY (Please check all that apply)

☐ Abnormal Mammogram ☐ Cancer ☐ Heart Disease ☐ Mental Illness
☐ Abnormal Menstruation ☐ Chronic Headache ☐ Hernia ☐ Prostate Disease
☐ Abnormal Pap Smear ☐ Circulation Problem ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Abnormal T B. test ☐ Colon Polyp ☐ High Cholesterol ☐ Seizure or Epilepsy
☐ Acid reflux ☐ Depression ☐ Hemorrhoids ☐ Sexually Transmitted Disease
☐ Active Tuberculosis ☐ Diabetes ☐ HIV or AIDS ☐ Skin Disease
☐ Allergies/Hay Fever ☐ Diverticulosis ☐ Intravenous Drug Use ☐ Stomach Ulcer
☐ Anemia ☐ Dialysis ☐ Liver Disease/Hepatitis ☐ Stroke
☐ Asthma ☐ Eating Disorder ☐ Lung Disease ☐ Thyroid Disease
☐ Blood Product Transfusion ☐ Gall Bladder Disease ☐ Lupus ☐ Other ____________________

FAMILY HISTORY (Please check all that apply and indicate relationship to family member)

☐ Asthma ☐ Depression ☐ High Cholesterol ☐ Prostate Cancer ☐ Tuberculosis
☐ Bleeding Disorder ☐ Diabetes ☐ Mental Illness ☐ Skin Cancer ☐ Thyroid Disease
☐ Breast Cancer ☐ Heart Attack ☐ Osteoporosis ☐ Stroke ☐ Ovarian Cancer
☐ Colon/Rectal Cancer ☐ High Blood Pressure ☐ Other __________________________

MEDICATIONS (List current medications and doses (incl. birth control or shots, non- prescription drugs, vitamins, supplements, ointments, creams, nasal sprays, inhalers and eye drops) _______________

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____
____

HOSPITAIZATIONS / MAJOR EVENTS: ______________________________

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____

ALLERGIES TO MEDICATIONS (please list): ______________________________

____

Allergic to: ☐ Latex ☐ Iodine / Dye ☐ Metal ☐ Food Allergies: ______________________

____

PREVENTIVE CARE:

Check and date all that apply: ☐ Mammogram ________________ ☐ Pap Smear________________
☐ DEXA Scan _____________ ☐ Colonoscopy __________________ ☐ Physical ________________
☐ Last Dental Exam _________ ☐ Last Eye Exam _______________

IMMUNIZATIONS: (Check if you had the disease or received the vaccine and list the year)

☐ Diphtherial/Tetanus ________________________ ☐ Pneumonia ______________________________
☐ Hepatitis A ________________________________ ☐ Polio ___________________________________
☐ Hepatitis B ________________________________ ☐ Small Pox _______________________________
☐ Gardasil (HPV Vaccine) ____________________ ☐ T.B. Skin Test __________________________
☐ Influenza __________________________________ Result: Positive/negative _________________
☐ Measles/ Mumps German Measles _____________ Treatment _______________________________
☐ Meningitis _________________________________ ☐ Zostavax _______________________________

Concerns / Comments: ____

Patient Signature: ______________________________ Date: _________________________________

☐ I acknowledge that this history is correct and complete