Welcome to:

Tysons Internal Medicine

We are honored to be your care provided and look forward to serving you!

Please note:

If you are unable to make your appointment, kindly notify us as soon as possible. Cancellations made less than **24 hours** before your appointment will result in a **$50.00 cancellation fee** to ensure our team's time and resources are respected.

All medications that require **prior authorization** application will result in **$15.00 administrative fee**.

Medications will not be refilled for durations longer than 90 days without a follow-up visit scheduled with our medical team either in person or through a virtual visit. If a follow-up visit is not possible, we will provide you with a 30-day refill for a **$10.00 refill fee**.
Office requires all pending balances to be clear at the time of your visit.

Thank you for your understanding and cooperation!

Signature: _____

Name: _____

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: _____
ZIP CODE FOR THIS CARD: _____

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) _____

_____
_____
_____
_____

HOSPITAIZATIONS / MAJOR EVENTS: _____

_____
_____

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