DR. LINDA COLEMAN & ASSOCIATES
Primary Care
Phone: 703-430-7090 | Fax: 703-444-98782 | 2 Pidgeon Hill Drive, Suite 400, Sterling, VA 20165

WELCOME

We are pleased you have chosen us for your Primary Care needs. We are dedicated to giving you the best of care while providing you with support and explanations regarding your condition. We hope this will help answer questions you may have concerning our practice.

LOCATION

We are located on the 4th floor of 2 Pidgeon Hill Drive, Suite 400 in Sterling, VA 20165. Our phone number is 703-430-7090 and our fax number is 703-444-9878.

REFERRALS

It is the responsibility of the patient to know and understand their insurance policy. Some insurance policies require the member to obtain a referral from their primary care provider before being seen by a specialist. Referrals and prior authorizations can be obtained by calling our referral line at 703-444-9496. You will be asked to leave necessary information such as type of insurance, name of doctor you will be seeing, diagnosis and appointment date. If all pertinent information is not received your referral cannot be processed. Please allow 72 hours for referrals to be processed. If an office visit is needed before a referral can be issued you will be contacted by the receptionist to make an appointment.

APPOINTMENT AND OFFICE HOURS

Visits are by appointment only and can be scheduled by calling the receptionist at 703-430-7090 between the hours of 8:00 a.m. and 5:00 p.m. Monday through Thursday and 8:00 a.m. and 12:00 p.m. Friday. If you are unable to keep an appointment, you must call us at least 24 hours in advance or there will be a $75 no show fee charged to your account which is not billable to your insurance company.

TELEPHONE CALLS

If you are concerned about your condition or have specific questions, please call the office. You will need to provide the nursing staff with all necessary information and indicate the degree of urgency of the call. The nursing staff can answer most questions. In the event your specific question cannot be handled by one of the nurses, your message will be relayed to one of the practitioners. Rather than try to handle non-emergency calls immediately, it is our practice to return such calls at regular intervals during the day. Please allow 24 hours for calls to be answered. When leaving your telephone message, kindly give all the telephone numbers at which you can be reached. Phone consults are subject to a $10-$20 fee which will be billed to the patient directly as they cannot be billed to your insurance company. Please keep in mind that after hours calls are for emergency problems only.

HOSPITAL ADMISSIONS

We work in close association with INOVA Loudoun Hospital for your inpatient care. All records and associated medical problems will be coordinated with Drs. Mendiguren & Rosenthal.

PRESCRIPTIONS/REFILLS

All prescriptions and requests for refills should be requested during normal office hours by calling our prescription line at 703-444-9496 or by having your pharmacy fax us a refill request. Please have your pharmacy telephone number, prescription name and dosage close at hand. After hours prescriptions will not be refilled until the next business day.

FORM FEES

Forms needing to be filled out by a provider (i.e., school physical form, disability paperwork) are subject to a $10-$50 form fee which cannot be billed to your insurance company.

EMERGENCIES

In the event that an emergency occurs during office hours, call the office and you will be given instructions. If you feel your condition requires immediate medical attention go to the nearest emergency room or visit our Immediate Care Center at 46440 Benedict Drive, #107, Sterling, VA 20164. Their phone number is 703-450-1125.

BILLING AND COLLECTIONS

Payment for office visits, including co-pays, is expected at the time of service. Payment may be made by cash, check, Visa, MasterCard, or American Express. If we participate with your insurance we will file an insurance claim for your office visit. Inability to pay should be discussed prior to your visit so that acceptable payment arrangements can be made.

Our billing department can be reached at 703-737-6001, Option 2. Before accounts are forwarded to a collection agency, we send multiple statements, as well as letters to the guarantor/policyholder, allowing ample time for payment arrangements to be discussed. If there is no response, this may result in your account being turned over to a collection agency.

NEW ADDRESS/INSURANCE INFORMATION

Please advise our staff of any new information, especially insurance updates, home addresses, and phone numbers so we may update our records. Having the same information as your insurance company is very critical. Claims submitted to an incorrect insurance provider may be denied due to timely filing issues and may become the patients responsibility.

DISMISSAL FROM THE PRACTICE

Rarely, it is necessary to dismiss a patient from our practice. However, missing three scheduled appointments, not addressing billing issues, perpetually failing to follow treatment plans as advised, and abuse of the staff are all considered grounds for terminating our relationship.

RELEASE OF INFORMATION

Dr. Coleman's office may disclose any or part of the medical record to my insurance company (or companies) for purpose of satisfying charges billed. I further understand that it may be necessary to contact my past or present employer(s) in regard to the insurance claim. For further information please see the HIPAA release form.

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RECEIPT OF OFFICE POLICY

I, ____, acknowledge receiving on _________________,
Print Patient Name Date

a copy of the Office Policy.

____ ________________________
Patient Signature Date

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PATIENT REGISTRATION (Please Print)

Last Name____________________________________First Name________________________M_____

Date of Birth_________________SS#______________________Sex____Marital Status____________

Address____

Race____________Ethnicity_____________________Preferred Language________________________

Home Phone_____________________Work______________________Cell______________________

Email____Employer____________________________

Pharmacy___________________________Location__________________Phone__________________

How did you hear about us?____

Emergency Contact____

Relationship to Patient___________________________Phone__________________________________

Primary Insurance Policy Holder_______________________________SS#________________________

Relationship to Patient____

Secondary Insurance Policy Holder_____________________________SS#________________________

Relationship to Patient____

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 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 all missed appointments of which I did not notify the medical office within a reasonable amount of time.
I authorize LMG to test my blood for hepatitis and/or 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.

Date___________________ Signature____