

Account Number _____

Patient Information

Name _____ Age _____ Sex: Male Female

Date of Birth (mo/day/yr) ____/____/____ Social Security # _____-____-_____

Address (No PO Boxes) _____

City _____ State _____ ZIP _____

Telephone Number (____) _____-_____ Work Number (____) _____-_____

Cell/Mobile/Pager (____) _____-_____ Email _____

Which Number May We Confirm Appointments With? Home Work Mobile
May we contact you via email with results? _____ (see communication policy)

Billing Address (If different from above) _____

City _____ State _____ ZIP _____

Relationship Status (Circle One) Married Partnered Single Widowed Divorced

Emergency Contact _____ Relationship _____

Telephone Number (____) _____-_____ Work Number (____) _____-_____

Patient Employer _____

Occupation _____

Primary Insurance

Please present your insurance card to our staff so that we may make a photocopy for our records.
You may skip this section if you present your insurance card to our staff.

Insurance Company Name _____

Telephone Number (____) _____-_____ Effective Date of Policy ____/____/____

Claims Address _____

City _____ State _____ ZIP _____

Primary Insured's Identification Number _____

Group Number _____ Primary Insured's Date of Birth ____/____/____

Your relationship to the Primary Insured _____

Secondary Insurance

Insurance Company Name _____

Telephone Number (_____) _____ - _____ Effective Date of Policy ____/____/____

Claims Address _____

City _____ State _____ ZIP _____

Primary Insured's Identification Number _____

Group Number _____ Primary Insured's Date of Birth ____/____/____

Your relationship to the Primary Insured _____

Authorization and Assignment of Benefits

I hereby authorize Capital Medical Associates, PC, or any of their agents or affiliates, to request payment from my insurance provider for services rendered on my behalf.

I hereby authorize Capital Medical Associates, PC, or any of their agents or affiliates, to release the necessary personal and medical information required by my insurance provider to secure payment.

Communication Policy

Appointments are available by contacting the front desk of the office. Correspondence via email will only be returned if the address matches the email address provided on this form. All reasonable precautions to maintain confidentiality will be taken but cannot be guaranteed. Email correspondence is limited to appointments, results and general questions only. **Never contact the office by email for a medical emergency, call the office for an appointment.** You may request to discontinue email correspondence with this office at any time.

Financial Policy

I have been presented with and agree to the terms and conditions as stated in the financial policy of Capital Medical Associates PC. Special services are subject to a fee.

Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed under Federal and State law, and outlining my rights regarding my health information.

I wish to make my personal medical information available to the following people/agencies:

I wish to place the following restrictions on my personal health information:

Capital Medical Associates PC Financial Policy

We firmly believe that a good physician/patient relationship is based upon understanding and good communication. This policy outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This financial policy has been established with these objectives in mind, and to avoid misunderstandings or disagreements concerning payment for professional services. A consistent collection policy will be maintained in the collection of accounts in order to maximize money due to the practice for services rendered.

Procedures:

1. The practice will file all claims on our patients' behalf to their insurance carrier for services rendered. It is the patients' responsibility to provide all insurance information and complete all necessary forms before leaving the office.
2. All co-payments, deductibles, co-insurance or any non covered service is due and payable at the time of service unless other payment arrangements have been made in advance.
3. Uninsured patients or patients without insurance identification cards are expected to pay for services in full at the time of service.
4. Any patient who pays for services in full and requests us to send the claims to an insurance carrier at a later date will have their funds reimbursed only after the insurance company makes payment.
5. Proof of payment may be required for any deductible met to another office or facility. Explanations of benefits or check copy are acceptable.
6. Payment forms accepted are cash, personal check, money order, Visa, Mastercard, American Express and Discover. All overdraft checks will have an additional \$50 fee added. Once an overdraft has occurred we will no longer accept personal checks for that account.
7. The business office will assist with claims filing questions and forwarding additional information to insurance companies. Specific coverage issues can only be answered by your insurance company's member services department or by referring to your explanation of benefits statement.
8. In the event a patient is unable to pay the full amount due the receptionist will set up a payment plan. In the event that the payment plan is not honored the account will be immediately turned over to a collection agency.

The following fees apply to special services provided by this office:

Telephone, email or fax consultations	\$50
Prescription prior authorizations	\$50
Provider statements and letters	\$50
Form completion	\$50
Medical record copy service per chart	\$50
Non urgent calls after hours	\$100

Cancellation of an annual physical examination with less than 24 hours notice is \$200.

Cancellation of any other office visit with less than 24 hours notice is \$100.

I have read, understand and agreed to the above statements by signing this document.

Patient Signature _____ Date _____

Patient Parent or Guardian _____