

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____ HOME PHONE #: _____

ADDRESS: _____ WORK PHONE: _____

CITY: _____ STATE: _____ DATE OF BIRTH: ____/____/____

ZIP CODE: _____ SEX (M/F): _____ SSN: _____ -- _____ -- _____

EMPLOYED (Y/N)/OCCUPATION: _____ MARITAL STATUS: Married/Single/Other

EMPLOYER NAME or SCHOOL NAME: _____

EMPLOYER or SCHOOL ADDRESS: _____

REFERRING PHYSICIAN NAME, ADDRESS and/or PHONE: _____

FAMILY PHYSICIAN NAME, ADDRESS and/or PHONE: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSHIP TO PATIENT: _____ EMERGENCY PHONE: _____

INSURANCE INFORMATION

PRIMARY INS COMPANY: _____ PHONE: (____) _____

ADDRESS: _____ ID#: _____

CITY: _____ STATE: _____ ZIP: _____ GROUP NAME/#: _____

POLICYHOLDER NAME: _____ EMPLOYER INS PLAN (YES/NO): _____

EMPLOYER OF POLICYHOLDER (If Employer Policy): _____ POLICYHOLDER DOB: _____

RELATIONSHIP OF PATIENT TO POLICYHOLDER (Check One Below):

___ SELF ___ HUSBAND ___ WIFE ___ CHILD ___ PARENT ___ OTHER

SECONDARY INS COMPANY: _____ PHONE: (____) _____

ADDRESS: _____ ID#: _____

CITY: _____ STATE: _____ ZIP: _____ GROUP NAME/#: _____

POLICYHOLDER NAME: _____ EMPLOYER INS PLAN (YES/NO): _____

EMPLOYER OF POLICYHOLDER (If Employer Policy): _____ POLICYHOLDER DOB: _____

RELATIONSHIP OF PATIENT TO POLICYHOLDER (Check One Below):

___ SELF ___ HUSBAND ___ WIFE ___ CHILD ___ PARENT ___ OTHER

ASSIGNMENT OF BENEFITS

TO ALL PATIENTS:

I HEREBY AUTHORIZE THIS PHYSICIAN TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED AND I AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO NORTHERN VIRGINIA PULMONARY AND CRITICAL CARE ASSOCIATES, P.C., OR ITS PHYSICIANS.

I CERTIFY THAT THE INFORMATION I HAVE REPORTED REGARDING INSURANCE COVERAGE IS CORRECT AND AUTHORIZE RELEASE OF ANY NECESSARY INFORMATION AND MEDICAL DOCUMENTATION FOR THIS OR ANY FUTURE CLAIM, TO MY INSURANCE CARRIER (AND FOR MEDICARE PART B BENEFITS TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION).

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES INCURRED. I FURTHER UNDERSTAND THAT IF MY ACCOUNT IS TURNED OVER TO AN ATTORNEY OR A COLLECTION AGENCY FOR NON-PAYMENT THAT I WILL BE RESPONSIBLE FOR ANY ADDITIONAL COSTS INCURRED INCLUDING COLLECTION FEES OF UP TO 33-1/3%, AS WELL AS ATTORNEY'S FEES AND COURT COSTS.

A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME IN WRITING.

SIGNATURE DATE

MEDICARE PATIENTS:

PATIENT NAME MEDICARE ID NUMBER

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS WHICH ARE PAYABLE TO ME, BE PAID DIRECTLY TO NORTHERN VIRGINIA PULMONARY AND CRITICAL CARE ASSOCIATES, P.C., OR ITS PHYSICIANS, ON MY BEHALF, FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION, AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE DATE

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS WHICH ARE PAYABLE TO ME, BE PAID DIRECTLY TO NORTHERN VIRGINIA PULMONARY AND CRITICAL CARE ASSOCIATES, P.C., OR ITS PHYSICIANS, ON MY BEHALF, FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY HEALTH INSURANCE CARRIERS (AS LISTED ABOVE), AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.