VASCULARCARE
Experts with Minimally Invasive Treatments

4255 Altamont Place, Suite 101
White Plains, MD 20695

6551 Loisdale Court, Suite 165
Springfield, VA 22150

240-412-0051

PATIENT NAME: LAST	FIRST		MIDDLE INITIAL
HOME ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		CELL PHONE
EMAIL			
SEX: FEMALE/MALE	MARITAL STATUS: SINGLE/SEPARATED/MARRIED/DIVORCED/WIDOWED		
DATE OF BIRTH	AGE		SOCIAL SECURITY NUMBER
EMPLOYER	PHONE		
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN		
PERSON TO CONTACT IN CASE OF EMERGENCY			PHONE NUMBER

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I AGREE TO PROMPTLY PAY ALL CHARGES WHEN BILLED FOR MEDICAL SERVICES RENDERED AND ACCEPT LEGAL RESPONSIBILITY FOR ANY AND ALL CHARGES FOR THE PATIENT NAMED ABOVE. I HAVE READ AND UNDERSTAND FULLY THE BILLING POLICY IMPLEMENTED BY THE PRACTICE OF THE CENTER FOR INTERVENTIONAL MEDICINE (CFIM). I ALSO TAKE FINANCIAL RESPONSIBILITY IF I SHOULD FAIL TO COMPLY WITH MY CONTRACTUAL AGREEMENT WITH MY HEALTH CARRIER AND NOT PRESENT AT THE TIME OF SERVICE DOCUMENTS REQUIRED TO PROCESS MY HEALTH CARE CLAIMS.

SIGNATURE: _____ DATE: _____

BILLING & INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
POLICY HOLDER'S NAME	POLICY HOLDER'S DATE OF BIRTH	POLICY HOLDER'S SS#
POLICY HOLDER'S EMPLOYER	RELATIONSHIP TO PATIENT	SPECIALIST COPAY
SECONDARY INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER
POLICY HOLDER'S NAME	POLICY HOLDER'S DATE OF BIRTH	POLICY HOLDER'S SS#
POLICY HOLDER'S EMPLOYER	RELATIONSHIP TO PATIENT	SPECIALIST COPAY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BILLING OFFICE.
I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO CFIM FOR ANY SERVICES FURNISHED TO ME. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.
I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTHCARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION.)

SIGNATURE _____ DATE_____

IF YOU FOUND US ONLINE WHICH SEARCH ENGINE DID YOU USE? GOOGLE, YAHOO or BING
DID YOU FIND US THROUGH AN ONLINE ADVERTISEMENT? _____WHICH ONE? _____
DID YOU HEAR ABOUT US THROUGH A FRIEND or FAMILY MEMBER?_____
DID YOU HEAR ABOUT US THROUGH A NEWSPAPER/MAGAZINE ADVERTISEMENT? _____WHICH ONE? _____