

# CAPITOL MEDICAL GROUP

8401 Connecticut Avenue, Suite 201 • Chevy Chase, Maryland 20815

**I understand that failure to provide any of the requested information on this form would mean that I will be held financially responsible for any services provided.**

**CHANGE OF ADDRESS**

• Please Print Clearly

**Telephone (301) 907-3960**

PATIENT NAME			First	Middle	Last	PT. SEX	PATIENT'S DATE OF BIRTH		PT. AGE
PATIENT'S HOME ADDRESS					APT NO.	CITY	STATE	ZIP CODE	ZIP CODE
FATHER'S FULL NAME				FATHER'S EMPLOYER NAME			FATHER'S WORK PHONE		FATHER'S HOME PHONE
MOTHER'S FULL NAME				MOTHER'S EMPLOYER NAME			MOTHER'S WORK PHONE		MOTHER'S HOME PHONE
CELL PHONES: MOM				DAD			BABY SITTER		
FULL NAME OF PATIENT'S LEGAL GUARDIAN OR GUARANTOR									
NEAREST RELATIVE/FRIEND CONTACT IN CASE OF EMERGENCY					RELATIONSHIP	WORK PHONE		HOME PHONE	
WHO REFERRED YOU				EMAIL ADDRESS:					
DRUG ALLERGIES/MEDICAL PROBLEMS									

### POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is payment is to be made at the time services are rendered. If we participate with your insurance, we will expect co-pay, patient responsibility, and any percentage due at the time of service. We will then submit your insurance claim. You are responsible for submitting claims to insurance companies with whom we do not participate. Payment is accepted in the form of cash, check, Money Order, Visa, or MasterCard.

There will be a finance charge applied to all accounts over thirty (30) days past due. If an account is sent to a collection agency to recover payment, the responsible financial party agrees to pay the amount in full, along with any fees charged by the collection agency.

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.

Date \_\_\_\_\_ X \_\_\_\_\_