

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.

PATIENT REGISTRATION • 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
FATHER'S FULL NAME			FATHER'S EMPLOYER NAME		FATHER'S WORK PHONE
MOTHER'S FULL NAME			MOTHER'S EMPLOYER NAME		MOTHER'S WORK 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
REFERRING PHYSICIAN			OTHER SOURCE OF REFERRAL		
DRUG ALLERGIES			KNOWN 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 _____

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME		LAST NAME		RELATIONSHIP TO PATIENT
	HOME ADDRESS			CITY	STATE
	EMPLOYER			WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME			ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS			SUBSCRIBER'S SOCIAL SECURITY	
	SUBSCRIBER'S NAME		SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS			WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

FAMILY MEMBERS

NAME	SIBLING'S DATE OF BIRTH	AGE	NAME	SIBLING'S DATE OF BIRTH	AGE
NAME	SIBLING'S DATE OF BIRTH	AGE	NAME	SIBLING'S DATE OF BIRTH	AGE
NAME	SIBLING'S DATE OF BIRTH	AGE	NAME	SIBLING'S DATE OF BIRTH	AGE

PATIENT AUTHORIZATION

I, _____, hereby authorize Capitol Medical Group, to apply for benefits on my behalf for covered services rendered. I request payment from _____ Insurance Company, be made directly to the above named providers.
NAME OF INSURANCE

I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any medical information for payment, treatment, and health care operations for this or any other related claim to the above-named billing agent, and / or insurance company named above. I understand that failure to provide any of the requested information on this form would mean I will be held financially responsible for any services provided. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by either me or the above-named carrier at any time in writing.

Date

Signature of Subscriber or Beneficiary

ACCOUNT NUMBER
