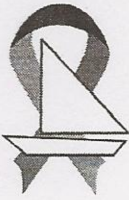

Date ______________

NEW PATIENT REGISTRATION

410.266.8010 • Fax: 443.782.2498

2001 Tidewater Colony Drive • Suite 102

Annapolis, Maryland 21401

PLEASE PRINT *(except where signature is requested)*

PATIENT: LAST NAME	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NO.
HOME: STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )
MARITAL STATUS ❑ single ❑ married ❑ other ______	EMAIL ADDRESS			CELL PHONE ( )
EMPLOYER		PATIENT'S TITLE / POSITION / JOB		
STREET ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ( )
REFERRING PHYSICIAN	LAST NAME	FIRST	MI	OFFICE PHONE ( )
STREET ADDRESS	CITY	STATE	ZIP CODE	
EMERGENCY CONTACT or LEGAL GUARDIAN RELATIONSHIP TO PATIENT ❑ parent ❑ guardian ❑ other ______	LAST NAME	FIRST	MI	CELL PHONE ( )
STREET ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

REASON FOR VISIT DATE OF FIRST SYMPTOM

CONDITION OR SYMPTOMS FOR WHICH YOU ARE SEEKING TREATMENT

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

PRINT FULL NAME OF RESPONSIBLE PARTY **SIGNATURE OF RESPONSIBLE PARTY** **TODAY'S DATE**

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREAT

I hereby assign all medical benefits to which I am entitled to Annapolis Lymphedema Center in the event they file for insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid for by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to: collection of service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over 90 days old. I hereby authorize said assignee to release all information necessary to secure pament of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Annapolis Lymphedema Center as may be dictated by prudent medical practice by my illness, injury, or condition. This document is intended as a waiver of liability for such treatment except for acts of negligence.

AUTHORIZED SIGNATURE **TODAY'S DATE**

PAYMENT POLICY

We will bill your primary insurance as a courtesy to you. Any co-pays will be due at the time of visit. We will also bill Medicare, which will be 80% of allowable charges. After an Explanation of Benefits is received, we will bill your secondary insurance. If no secondary is available, the balance will be billed to you. Once the above information is verified, we will provide you with a written description of your insurance coverage for our service.

Thank you for allowing us the opportunity to serve you. If you have any questions about the payment policy of any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to its terms.

AUTHORIZED SIGNATURE **TODAY'S DATE**

Rev. 9/2007