HILLENDALE MEDICAL CARE
13168 CENTER POINTE WAY SUITE 101
WOODBRIDGE VA 22193
703-730-2000

PATIENT AND INSURANCE INFORMATION FORM

ENGLISH

NAME (FIRST, MIDDLE, LAST) : SEX: DATE OF BIRTH: SOCIAL SECURITY NUMBER:	HOME PHONE NUMBER: WORK PHONE NUMBER: CELL PHONE NUMBER:
MINOR'S FATHER'S NAME : SOCIAL SECURITY NUMBER: DATE OF BIRTH:	MINOR'S MOTHER'S NAME SOCIAL SECURITY NUMBER DATE OF BIRTH:
PERMANENT ADDRESS :STREET AND APT #	PERMANENT ADDRESS: CITY , STATE AND ZIP CODE
OCCUPATION: EMPLYOER NAME:	EMPLOYER ADDRESS: EMPLOYER PHONE:
PREVIOUS PHYSICIAN 'S NAME: PHONE NUMBER :	PREVIOUS PHYSICIAN ADDRESS :
MARITAL STATUS: (circle one) SINGLE MARRIED SEPRATED DIVORCED WIDOWED	WHO REFFERED YOU TO OUR PRACTICE : NEWSPAPER - FRIEND - RADIO - TV - FLYER PHONE BOOK - INSURANCE - OTHER _____
NAME OF EMERGENCY CONTACT: PHONE: RELATION:	EMERGENCY CONTACT ADDRESS:
NAME OF POLICYHOLDER: SEX: DATE OF BIRTH: SOCIAL SECURITY NUMBER:	TYPE OF POLICY: (circle one) HMO PPO OTHER
NAME OF PRIMARY INSURANCE: INSURANCE ID #: GROUP#:	NAME OF SECONDARY INSURANCE: INSURANCE ID #: GROUP#:

I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPOSIBLE FOR PAYMENT.
I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____

SIGNATURE OF PERSON FINANCIALLY RESPONSIBLE DATE ACCEPTED BY

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PATIENT INFORMATION

Welcome to Hillendale Medical Care. It is to our mutual benefit that our patients understand our Payment Policy. We make every effort to keep the cost of your medical care to a minimum. Due to the expense of processing insurance claims, we request full payment at the time of your visit if you have a deductible. If your insurance company is one with which we participate, we will bill your insurance company as agreed between to Hillendale Medical Care and the respective insurance company. Ultimately, responsibility for payment lies with the patient. Payment not received from the insurance company within 45 days becomes the responsibility of the patient. Please sign the following authorization so that payment may be made to Hillendale Medical Care for services rendered and billed by Hillendale Medical Care.

Patient: _____

Address: _____

OUR PAYMENT POLICY

I, the undersigned, hereby authorize Hillendale Medical Care to apply for benefits on my behalf for covered services rendered to me, not paid in full today.

I REQUEST PAYMENT FROM MY INSURANCE CARRIER, IF ANY, BE MADE DIRECTLY TO HILLENDALE MEDICAL CARE UNLESS OTHERWISE INDICATED ON THE CLAIM.

I certify that the information reported with regard to insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claim, to the insurance carrier. In making this assignment, I understand and agree that I am financially responsible for changes not paid under this insurance policy.

RELEASE INFORMATION

Hillendale Medical Care may disclose any or part of this medical record to my insurance company (or companies) for purposes of satisfying charges billed. I further understand that it may be necessary to contact my past or present employer(s) in regard to the insurance claim.

GUARANTEE OF PAYMENT

To Hillendale Medical Care: For and in consideration of services rendered, or to be rendered to the above named patient. I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. Interest on the unpaid balance at the rate of eighteen percent (18%) per annum will be accrued 45 days after services rendered. In the event the account must be placed with an attorney or collection agency to obtain payment, I shall be responsible for all attorney and collection agency fees incurred.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS

_____
Signature of Person Financially Responsible Witness

Date:
_____

Address (If other than
patient's):_____