Healthcare of Greater Washington Patient Registration Form

Patient Information

Name: Last:	First:	Mi:
Address:		Apt #:
City:	State:	Zip Code:
Home #:	Cell #:	Work #:

Sex:	SS#:	**Email Required:**
Birthday:	Occupation:	
Employer:	Department:	
Employer Address:	Employer City, State, Zip:	
Emergency Contact (Not Your Home) and Telephone:		

Guarantor Information

Name: Last:	First:	Mi:
Address:		Apt #:
City:	State:	Zip Code:
Home #:	Cell #:	Work #:

Sex:	SS#:	Email Address:
Birthday:	Occupation:	
Employer:	Department:	
Employer Address:	Employer City, State, Zip:	
Emergency Contact (Not Your Home) and Telephone:		

I understand and agree, that I will pay any non-covered service or deductible that is required by my insurer and pay my co-pay at the time of service.

Patient or Responsible Party Authorizations:

I, the undersigned, hereby authorize Healthcare of Greater Washington to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to Healthcare of Greater Washington. I realize that I may request non-covered services and agree that I am responsible personally for any charges due to non-covered services. I consent to medical examination and treatment for myself, or the minor child named above whose parent or guardian I am.

I certify that the information I have provided is correct. I authorized the release of any necessary information, including medical information, to the insurance carrier(s) named above, laboratory or, (in case of Medicare benefits) to the Social Security Administration and Health Care Financing Administration in order to determine benefits to which I am entitled.

I agree to pay a fee for $35.00 for checks returned, $35.00 for missed appointments without 24 hour notice, and a $35.00 processing charge for all accounts sent to a collection agency.

Date: Signature: Name: (print)

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