

H. RUSSELL WRIGHT, JR., M.D., P.A.

PATIENT REGISTRATION (Please Print)

PATIENT NAME		Last	First	M
Home Address		Apt#	City	State Zip Code
Date of Birth	Age	Sex	Social Security #	
Home Phone #	Cell #	Work Phone #	Pharmacy & Phone #	
Employer/School	Address		Phone #	
Do you have Health Insurance through your work? _____ yes _____ no				
Spouse/Parent/Guardian/Next of Kin			Work Phone #	

PHYSICIAN INFORMATION

Referring Physician or Person	Address	Phone #
Reason for Visit		
Family Physician	Address	Phone #

BILLING INFORMATION

Financially Responsible Person:	Self Spouse	Name if Different from Patient	Home Phone #
Please circle Parent Other			
Person's Address (if different from Patient)			
Financially Responsible Person's Employer	Employer Address	Work Phone #	

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Patients who carry health care insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You are responsible for payments of your account within the limits of our credit policy. We will, though, be very happy to help you with any problem that may arise concerning your insurance.

INSURANCE INFORMATION

Policyholder: Self Spouse	Primary Insurance Co. Name	Subscribers Name	Date of Birth
Please circle Parent Other			
Subscriber's Employer	Subscribers Social Security #	ID/Policy #	Group #
Insurance Company Address			
Secondary Insurance Co. Name	Subscribers Name	Date of Birth	Social Security #
Insurance Company Address		ID/Policy #	Group #

PATIENT'S AUTHORIZATION

I, _____ hereby authorize H. Russell Wright, Jr., M.D. to apply for benefits on my behalf for covered services rendered. I request payment from Blue Shield of Maryland, Medicare and/or _____ be made directly to H. Russell Wright, Jr., M.D. (or in the case of Medicare Part B benefits, to myself or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above billing agent, Blue Shield of Maryland (or in the case of Medicare Part B Benefits, to the Social Security Administration and Health Care Financing Administration) and / or _____. I permit a copy of this authorization to be used in place of original. This authorization may be revoked by either me or above named carrier at any time in writing.

Please see next page

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CONSENT & ASSIGNMENT

PLEASE READ BEFORE SIGNING

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (Title XVIII). I permit a copy of this authorization to be used in place of original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non-covered charges.

CAREFIRST BLUE CROSS / BLUE SHIELD OF MARYLAND

I authorize release of any medical information necessary to process this claim. For charges of a participating provider, I understand that I am responsible for any health insurance deductibles, co-insurance (co-pay) and non covered charges.

LEGAL ASSIGNMENT(applicable to Physician Services)

The undersigned expressly agrees that if, upon default, this matter is referred to collections, the undersigned agrees to pay attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith, as well as private process server fees.

INSURANCE ASSIGNMENT

I authorize and assign payment directly to the physician involved in my treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges **not covered** by my insurance.

MANAGED CARE

I understand that I did not provide a referral for my visit with Dr. H. Russell Wright, Jr. I understand that if a referral is needed for my visit and/or procedure, that I am financially responsible for the full amount of the visit with Dr. H. Russell Wright, Jr.

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

CANCELLATION & MISSED APPOINTMENT FEES

I understand that if I miss my scheduled appointment, or I do not cancel my appointment within 24 hours of the scheduled appointment, I will be charged a fee of \$25.00. I also understand that if allergy testing is scheduled for me and I do not cancel this appointment within 24 hours of the testing, I will be charged a fee of \$100.00. **Exceptions will be made for true emergencies only.**

GUARANTEE

As an inducement for the providing of services to the patient, the undersigned absolutely and unconditionally guarantees to H. Russell Wright, Jr., M.D., P.A, and its successor and assigns, the full and completed payment due by the patient, as and when the same comes due.

Signature: _____ Date: ____/____/____