POTOMAC ARTHRITIS & RHEUMATISM REGISTRATION FORM

Date_____

Name_____

Home Phone_____ Cell Phone_____

Address_____

City_____ State_____ Zip Code_____

Date of Birth_____ Gender_____

In case of emergency who should be notified?

_____Phone_____

PRIMARY INSURANCE: _____

ID# _____ Group#_____

SECONDARY INSURANCE:_____

ID#_____ Group# _____

ASSIGNMENT & RELEASE:

I certify that I have insurance with the above and assign directly to Potomac Arthritis & Rheumatism Madalene K Greene, MD PC all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named physician may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I further understand that if I am billed after a claim is processed, I will remit payment promptly. If rebilling is necessary, a 10% service charge will be added to the bill. In the unfortunate event your account becomes past due and is placed with a collection agency or attorney, you will be responsible for a collection fee equal to 35% of any outstanding balance.

(signature)_____