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| Final CIM Logo | 4255 Altamont Place, Suite 101  White Plains, MD 20695  240-412-0051  6551 Loisdale Court, Suite 165  Springfield, VA 22150  571-494-1445 |

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| PATIENT NAME: LAST FIRST MIDDLE INITIAL |
| HOME ADDRESS CITY STATE ZIP CODE |
| HOME PHONE WORK PHONE CELL PHONE |
| EMAIL |
| SEX: FEMALE/MALE MARTIAL STATUS: SINGLE/SEPARATED/MARRIED/DIVORCED/WIDOWED |
| DATE OF BIRTH AGE SOCIAL SECURITY NUMBER |
| EMPLOYER PHONE |
| REFERRING PHYSICIAN PRIMARY CARE PHYSICIAN |
| PERSON TO CONTACT IN CASE OF EMERGENCY PHONE NUMBER |

**POLICY CONCERNING PAYMENT OF MEDICAL BILLS**

**I AGREE TO PROMPTLY PAY ALL CHARGES WHEN BILLED FOR MEDICAL SERVICES RENDERED AND ACCEPT LEGAL RESPONSIBILITY FOR ANY AND ALL CHARGES FOR THE PATIENT NAMED ABOVE. I HAVE READ AND UNDERSTAND FULLY THE BILLING POLICY IMPLEMENTED BY THE PRACTICE OF THE CENTER FOR INTERVENTIONAL MEDICINE (CFIM). I ALSO TAKE FINANCIAL RESPONSIBILITY IF I SHOULD FAIL TO COMPLY WITH MY CONTRACTURAL AGREEMENT WITH MY HEALTH CARRIER AND NOT PRESENT AT THE TIME OF SERVICE DOCUMENTS REQUIRED TO PROCESS MY HEALTHCARE CLAIMS.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BILLING & INSURANCE INFORMATION**

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| INSURANCE COMPANY POLICY NUMBER GROUP NUMBER |
| POLICY HOLDER’S NAME POLICY HOLDER’S DATE OF BIRTH POLICY HOLDER’S SS# |
| POLICY HOLDER’S EMPLOYER RELATIONSHIP TO PATIENT SPECIALIST COPAY |
| SECONDARY INSURANCE COMPANY POLICY NUMBER GROUP NUMBER |
| POLICY HOLDER’S NAME POLICY HOLDER’S DATE OF BIRTH POLICY HOLDER’S SS# |
| POLICY HOLDER’S EMPLOYER RELATIONSHIP TO PATIENT SPECIALIST COPAY |

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BILLING OFFICE.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO CFIM FOR ANY SERVICES FURNISHED TO ME. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM/OTHER INSURANCE COMPANY CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. UNDERSTAND IT IS MANDATORY TO NOTIFY THE HEALTHCARE PROVIDER OF ANY OTHER PARTY WHO MAY BE RESPONSIBLE FOR PAYING FOR MY TREATMENT. (SECTION 1128B OF THE SOCIAL SECURITY ACT AND 31 U.S.C. 3801-3812 PROVIDES PENALTIES FOR WITHHOLDING THIS INFORMATION.)

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOW DID YOU HEAR ABOUT US? FRIEND/FAMILY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NEWSPAPER/MAGAZINE(WHICHONE?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INTERNET WEBSITE (WHICH ONE?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REF BY DR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**