ADULT & PEDIATRIC UROLOGISTS OF NORTHERN VA., LTD.

JOHN W. KLOUSIA, M.D. · GEORGE W. TAWIL, M.D. · YOUSEF SALEM, M.D.

PATIENT REGISTRATION

DATE ______________________

Please Print Clearly

PATIENT NAME First Middle Last				DATE OF BIRTH	AGE
HOME ADDRESS	APT. NO.	CITY	STATE	ZIP CODE	
OCCUPATION / EMPLOYED ☐ RETIRED ☐ STUDENT: ☐FT ☐PT	SOCIAL SECURITY NO.	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W	SEX	HOME PHONE	
EMPLOYER (or previous employer, if retired)	ADDRESS			WORK PHONE	
SPOUSE (OR PARENT) NAME	SPOUSE (OR PARENT) EMPLOYER			SPOUSE (OR PARENT) WORK PHONE	
SPOUSE (OR PARENT) ADDRESS					
NEAREST RELATIVE / FRIEND	RELATIONSHIP	HOME PHONE		WORK PHONE	
RELATIVE / FRIEND ADDRESS					
REFERRING PHYSICIAN	ADDRESS			TELEPHONE	

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, Money Order, Visa, MasterCard or Discover.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Other (Specify)____________________

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. X______________________________

BILLING AND INSURANCE INFORMATION

SEND BILL TO	FIRST NAME / LAST NAME			RELATIONSHIP TO PATIENT
	HOME ADDRESS		CITY	STATE
	EMPLOYER		WORK PHONE	HOME PHONE
PRIMARY INSURANCE	INSURANCE COMPANY NAME		ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
SECONDARY INSURANCE	INSURANCE COMPANY NAME / IS THIS THROUGH EMPLOYER ☐ OR INDIVIDUAL ☐		ID OR POLICY NUMBER	GROUP / CODE
	INSURANCE COMPANY ADDRESS		SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE
	SUBSCRIBER'S NAME	SEX	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS		WORK PHONE	SUBSCRIBER'S DATE OF BIRTH

PATIENT AUTHORIZATION

I,______________________________, hereby authorize Adult & Pediatric Urologists of Northern Va., Ltd., to apply for benefits on my behalf for covered services rendered. I request payment from BC /BS National Capital Area, Blue Shield of Virginia, Medicare, and/or______________________________ (Name of Other Ins Co) Insurance Company, be made directly to the above-named provider (or in case of Medicare Part B benefits, to myself or 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-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to ______________________________ (Name of Medigap Carrier) any information needed to determine these benefits payable for related services.

______________________ *Date*

______________________________ *Signature of Subscriber or Beneficiary*

ACCOUNT NUMBER