Loudoun Walk In Medical Center

vers 1 dated 24Sep2010

44320 Premier Plaza – Suite 120, Ashburn, VA 20147
Tel: (703) 726-9056; Fax: (703) 726-9058

Account #:

REGISTRATION SHEET

NAME:_____
(FIRST) (MI) (LAST)

ADDRESS:_____
(STREET)

_____
(CITY) (STATE) (ZIP)

HOME TEL: ( )_____ WORK TEL: ( )_____

LOCAL TEL: ( )_____ E-MAIL ADDRESS:_____
(IF DIFFERENT FROM HOME TEL.)

DATE OF BIRTH:_____ SS #:_____
(MONTH/DATE/YEAR)

SEX: F / M MARITAL STATUS: Single/Married/Separated/Divorced/Widowed

EMPLOYER/SCHOOL:_____

ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

PRIMARY INSURANCE CARRIER:_____

INSURED'S NAME:_____
(FIRST) (MI) (LAST)

SOCIAL SECURITY #:_____ BIRTH DATE:_____

PATIENT'S RELATIONSHIP TO INSURED:_____

INSURED'S EMPLOYER:_____

SECONDARY INSURANCE CARRIER:_____

INSURED'S NAME:_____

SOCIAL SECURITY #_____BIRTH DATE_____

PATIENT'S RELATIONSHIP TO INSURED:_____

NEXT OF KIN:_____
(FIRST) (MI) (LAST)

ADDRESS:_____ ZIP_____
(STREET) (CITY)

SOCIAL SECURITY #:_____ HOME TEL: ( )_____

Authorization/ Assignment/ Responsibility Statement

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RECEIVED, INCLUDING, BUT NOT LIMITED TO, THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS AND ANY NON-COVERED SERVICES BY MY INSURANCE COMPANY. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS FOR MYSELF TO LOUDOUN WALK IN MEDICAL CENTER AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AGREE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON ANY OUTSTANDING BALANCES ON MY ACCOUNT.

Signed_____ Date_____
(Patient/Parent/Guardian/Next of Kin) (M/D/Y)