WOODBRIDGE INTERNAL MEDICINE
REGISTRATION FORM

Patient Information (Please Print)

Last name:	First: Today's Date:	Middle:
Sex: ◻ Male ◻ Female	Birth Date: / /	Age:
Social Security No: - -	Marital Status: ◻ Single ◻ Married ◻ Divorced ◻ Widowed	
Street address:	City, State, Zip:	
Home Phone:	Work Phone:	Cell Phone:
Occupation:	Employer:	Address:
Referred to office by:		
Pharmacy Name:		

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)			
PLEASE INDICATE **PRIMARY** INSURANCE:			
SUBSCRIBER'S NAME:	SSN:	DOB:	
GROUP NO:	POLICY NO:	CO-PAYMENT:$	DEDUCTABLE:$
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ◻ SELF ◻ SPOUSE ◻ CHILD ◻ OTHER			
PLEASE INDICATE **SECONDARY** INSURANCE:			
SUBSCRIBER'S NAME:	SSN:	DOB:	
GROUP NO:	POLICY NO:	CO-PAYMENT:$	DEDUCTABLE:$
PATIENT'S RELATIONSHIP TO SUBSCRIBER: ◻ SELF ◻ SPOUSE ◻ CHILD ◻ OTHER			
EMERGENCY CONTACT: Name: Phone No:		Relationship:	

1. **AUTHORITY FOR TREATMENT**: I hereby authorize Woodbridge Internal Medicine, P.C and/or doctors in charge of the patient to administer such medication and to perform treatment that may be deemed necessary or advisable in the treatment of the patient.
2. **RELEASE OF INFORMATION**: I hereby authorize Woodbridge Internal Medicine, P.C to release any information pertaining to my health care, test results, billing and/or accounting information to Medicare or my insurance or Insurances Company. I also authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Woodbridge Internal Medicine PC and/or the doctor indicated on the claim.
3. Hereby I authorize Woodbridge Internal Medicine, P.C to release any medical information pertaining to my health care, test result to the following person(s) or agencies. ◻ Spouse ◻ Other
4. I understand I am financially responsible for any balance not covered by Medicare or my insurance company.

Patient/Guardian signature______________________ Print name_____________________ Date_____________

WOODBRIDGE INTERNAL MEDICINE

Office policies:

1. **Payments: Are expected when Services are rendered**, Payable by cash, check, or credit. We also do not except any post dated checks. Any unpaid balance left from your insurance company, will be left for the responsible party to pay. All self pay Patients must pay by credit card or cash. For patients that have insurance, and will like to pay their co-pays with a check will be able to. If your check does come back bounced we will apply a fee of $35 and we will no longer accept any checks from the responsible party. As of August1, 2009 All new patients must present a picture identification, if ID is not present we will not be able to keep your appointment.

2. **Refills:** At the time of each visit we give you enough prescription refills until your next appointment. We also provide pharmacy request prescription refills by fax or phone, if you need refill you need contact your pharmacy, If you miss your appointment we will not provide more than one month refill.

3. **Missed appointment:** If you are not able to make your appointment please let us know 48 hours before your appointment, If you miss more than 2 appointments we are not able to follow you as a patient.

4. **Outstanding balance:** All outstanding balances after 90 days will turn to collection agency automatically. I agree and understand that I am personally liable to the medical service provider for payment of any balance on my account or on any account for which I am responsible as a parent or guardian (which may include professional service fees, missed appointment fees, bounced check charges, etc.) regardless of whether insurance benefits have been applied for or received, including interest on any outstanding balance(s) at the rate of 18% per annum accruing 30 days for the issuance date of the statement(s) and for any and all collection costs or fees, including but not limited to, 40% attorney's fees and court costs if the account(s) is/are turned over to a third party and/or attorney for collection. I agree and understand that if I do not dispute in writing the amounts and charges set forth in any statement within 30 days after its issuance date, that I am agreeing that the amounts and charges set forth in any statements are fair, reasonable and accurate. I agree and understand that if I file an action/counterclaim against the medical service provider/practice and the medical service provider/practice incurs any costs and attorney's fees for its/their defense, I am liable for such costs and attorney's fees if the medical service provider/practice is the prevailing party in said proceeding, which shall include, but not be limited to, bankruptcy, arbitration, mediation, litigation or other processes. We need credit card information to see patient with outstanding balance more than 60 days. If you need payment plan please contact office manager.

5. **Referral:** patients are responsible to make appointment for own referral; if you need help please let us know.

I agree with above office polices

Signature ________________________________ Date____________________

WOODBRIDGE INTERNAL MEDICINE

Authorization to charge credit card:

I authorize Woodbridge Internal Medicine PC to charge my credit card for all copayment, deductable and all outstanding balance.

Name on credit card:

Credit card type: VISA Master card Discover American express

Card number ________ ________ ________ ________

EXP. Date: ____/____ security number: __________________

Signature:__________________________ Print name_____________________ Date____________________