ADVANCED ENT SPECIALISTS

LOUDOUN MEDICAL GROUP

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth (mm,dd,yy)	Sex	Marital Status

Street Address	City/State	Zip Code

Home Telephone	Work Telephone	Cell Phone

Email Address

RESPONSIBLE PARTY / BILLING INFORMATION

Last Name	First Name	Middle Initial

Street Address	City/State	Zip Code

Home Telephone	Social Security

Employer	Employer Telephone

PRIMARY INSURANCE INFORMATION

Name of Company	Group Number	Policy Number

Insured's Name	Date of Birth	Relationship	Social Security

Insured's Employer	Employer's Telephone

SECONDARY INSURANCE INFORMATION

Name of Company	Group Number	Policy Number

Insured's Name	Date of Birth	Relationship	Social Security

Insured's Employer	Employer's Telephone

PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders or any third party service acting for LMG, PC, or any of its affiliates.

I agree to promptly pay for services rendered for me of the patient named above. If I fail to meet my financial commitment to LMG and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.

I authorize LMG to test my blood for hepatitis and/or the AIDS virus, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupations Safety and Health Administration.

Signature____ Date ______________________________