PHYSICIAN ASSOCIATES
6000 EXECUTIVE BLVD SUITE 300
ROCKVILLE, MD 20852
301-468-8999

Please Print Clearly:

Patient_____**Date**_____
First Name Middle Name Last Name

Street Address_____**City**_____**State**_____**Zip**_____

Home Phone ( )_____ **Work Phone** ( )_____

Sex: Male☐ Female☐ **Date of Birth**: _____/_____/_____ **Social Security**_____

Occupation:_____ Retired: yes☐ no☐ Student: yes☐ no☐ (If yes Full Time?_____)

Employer: _____ Marital Status: single☐ married☐ separated☐ divorced☐ widowed☐

Nearest Relative/Friend

Name: Relationship:

Address:_____Home Phone:_____

Work Phone:_____

Previous Physician or Referring Physician_____**Office Phone**_____

Address:_____

BILLING AND HEALTH INSURANCE INFORMATION

Send Bill To:

First Name: **Last Name:** **Relationship to Patient**

Address: **City:** **State:** **Zip:**

Home Phone: **Work Phone:**

Primary Insurance:

Subscriber's Name/Social Security # **Sex: Male☐ Female☐ Date of Birth**:___/___/___
Relationship to Patient:

Address: **City:** **State:** **Zip:**

Home Number: **Work Number:** **Employer**

Secondary Insurance:

Subscriber's Name: **Sex: Male☐ Female☐ Date of Birth___/___/___**
Relationship to Patient

Address: **City:** **State:** **Zip:**

Home Phone: **Work Number:** **Employer:**

Insurance Company: **ID #:** **Group #:**

Our policy is payment is to be made at the time services are rendered. Payment may be made by cash, Visa or MasterCard. Notice to all Medicare patients- certain services Provided by this office are considered non-covered by Medicare, i.e, flu vaccinations and telephone communications. You will be asked for payment for these services.

Appointments Must Be Cancelled At Least 24 Hours Prior To Appointment Time To Avoid Charges To Your Account

Returned Checks And Accounts With Balances Over 30 Days Old May Be Subject To Additional Collection Fees And Interest.

I agree to promptly pay all charges billed for medical services rendered and accept legal responsibility for any and all charges for the name above.

Signature_____**Date:**_____

Patient Authorization

I,_____, herby authorize Physician Associates to appy for benefits on my behalf for covered services rendered. I release payment from BLUE SHIELD

OF NCA, MEDICARE, MDIPA, and or /_____insurance company, be made directly to the above named provider.

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 Financial 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 or physician/supplier. I authorize any holder of medical information about me to release to _____(medigap carrier).

Signature_____**Date**:_____