INSURANCE INFORMATION *continued*

Secondary Ins:_____ ID #: _____

Address: _____ Group #: _____

_____ Group Name: _____

Policyholder Name: _____ Policyholder DOB: _____

Policyholder Patient Relationship: ☐ self ☐ spouse ☐ child ☐ other Policyholder SSN: _____

IMPORTANT INFORMATION: Providing us with your household income range and family size will aide us in receiving federal funding *(circle one)*

$0-$10,000 (1)☐ $10,001-$15,000 (2)☐ $15,001-$20,000 (3)☐ $20,001-$25,000 (4)☐ $25,001-$30,000 (5)☐ $30,001-$35,000 (6)☐ $35,001 and above (7)☐

Family Size: _____ (total number of family members that reside in the same home)

IN CASE OF EMERGENCY, please provide the following information:

_____ _____ _____

Contact Name **Relationship** **Contact Phone Number**

Please tell us how you learned of Xpress Medical Specialties:

METHOD OF PAYMENT

_____ *(Initial)* I understand and acknowledge that payment is due at the time service is rendered. This includes all co-payments and co-insurance responsibilities. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen. We accept Cash, Checks, Money Orders, Visa, Mastercard, American Express, Discover. **YOU WILL BE CHARGED $25 IF YOU MISS YOUR APPOINTMENT AND DO NOT GIVE US 24-HOUR NOTICE.**

INSURANCE AUTHORIZATION, ASSIGNMENT AND PAYMENT OF SERVICES

_____ *(Initial)* I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to **Xpress Medical Specialties** for any services furnished me by that party who accepts assignment/clinical provider. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to be released in order to process payment of such services. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for treatment. I also understand that it is my responsibility to be knowledgeable of my insurance benefits and requirements. I understand that based on my health insurance policy, there may be services that the Clinical Provider of **XMS** may deem necessary that may not be covered by my health insurance, and I shall be held responsible for the payment of such services. I understand and acknowledge that payment is due at the time service is rendered. This includes co-payments, patient responsibility percentage of office visit/procedural charge and any previous back charges. Any variation to this policy must be pre-arranged through our Accounting Department, prior to being seen.

AUTHORIZATION TO TREAT

_____ *(Initial)* Permission is hereby given to the Clinical Providers of **Xpress Medical Specialties (XMS)** , to administer such diagnostic, operative, or treatment procedures to the above named patient that are deemed necessary.

ADVANCE DIRECTIVE

_____ *(Initial)* I acknowledge receipt of "Advance Directives" pamphlet/form. This information was given to me *as* part of my "New Patient" documents. I fully intend to read this pamphlet, and should I decide to choose the use of the advance directives, I will complete the form and will return the signed document back to **(XMS)**to maintain with my medical records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of this provider's *Notice of Privacy Policies*, detailing how my information may be used and disclosed as permitted under federal and state law.

The below signature acknowledges your agreement to the above disclosures:

X _____ **Date:** _____

_____ _____

Signature of Patient/Personal Representative **Relation to Patient**

THE HEALTH CENTER, LLC

12200 Annapolis Rd Ste225, Glenn Dale, MD 20769
Ph: 301-262-2168 Fax: 301-3906243

Patient Registration Form

PATIENT INFORMATION

Today's Date: _____

_____ Patient's Social Security Number | _____ Date of Birth (xx/xx/xxxx) | _____ Age | Sex (M/F): _____

_____ Patient's Last Name | _____ First Name | _____ Initial | _____ Suffix (ex. Sr, Jr)

_____
Patient's Complete Address (if mailing address is PO Box we still also require your house #, street name and apt. # if applicable)

_____ City | _____ State | _____ Zip Code | _____ County

_____ Patient's Home Telephone # | _____ Patient's Cell Phone # | _____ Patient's Work Telephone # | _____ Patient's Email Address

Marital Status (circle one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient Maiden/Alias Name (or if the patient has been here before under a different name): _____

Race (circle one): ☐ Asian ☐ Black/African American (not hispanic or latino) ☐ Hispanic or Latino ☐ American Indian or Alaskan Native ☐ White ☐ Other/Unreported or refuse to state

Ethnicity (circle one): ☐ Hispanic ☐ Non-Latino ☐ Unreported/Refused to Report

Language Preference (circle one): ☐ English ☐ Spanish ☐ Other: _____

Patient a Migrant Worker: ☐ Yes ☐ No **Patient Homeless:** ☐ Yes ☐ No **Patient require translation services:** ☐ Yes ☐ No

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Military Duty ☐ Retired ☐ Not Employed

School Status (if 18+ age): ☐ Full-Time ☐ Part-Time ☐ Not a Student **Veteran (circle one):** ☐ True ☐ False

If the patient is not the responsible party for the bills associated with services received, please complete the following:

_____ Responsible Party Last Name | _____ First Name | _____ Intl | _____ Suffix

_____ Responsible Party Address | City | State | Zip Code

_____ Resp. Party Home # | _____ Resp. Party Work # | _____ Resp. Party Cell # | _____ Resp. Party SSN | _____ Resp. Party DOB

INSURANCE INFORMATION

Primary Ins: _____ ID #: _____

Address: _____ Group #: _____

_____ Group Name: _____

Policyholder Name: _____ Policyholder DOB: _____

Policyholder Patient Relationship: ☐ self ☐ spouse ☐ child ☐ other Policyholder SSN: _____