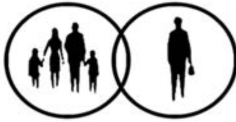

Chantilly Family Practice Center

Dr. Rajesh N. Mehra, Medical Director

4437 Brookfield Corporate Drive - Chantilly, VA 20151 - Office (703) 968 - 7277 Fax (703) 968 - 5644

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Name: (First, Middle, Last)		Home Phone:	
Home Address: APT No:		Work Phone:	
City:	State: Zip:	Gender: ❑ Male ❑ Female	Date Of Birth:
Social Security No:		Marital Status:	
If patient is a minor, parent's name:			
Parent's address: (If different)		Parent's Work No:	
Patient's Employer:		Occupation:	
Employer's Address:	City:	State:	Zip:
Emergency Contact:	Relationship:	Emergency contact phone No:	

How did you hear of us? __Friend / Relative __Insurance CO. __Phone Book __Ref. Doctor __Employer __Television __Newspaper __ Magazine __Coupon __Other

If other, please specify:

Reason for visit:	Date Occurred:

BILLING AND INSURANCE INFORMATION

Primary Insurance Company:			Phone No:
Ins. Company Address:	City:	State:	Zip:
Policy Holder's Name and DOB:			Relationship:
Policy Holder's SSNo:		Employer:	
Date Effective:	ID/Policy No:	Group Name/No:	
Secondary Insurance Company:			Phone No:
Secondary Ins. Company Address:	City:	State:	Zip:
Policy Holder's Name and DOB:			Relationship:
Policy Holder's SSNo:		Employer:	
Date Effective:	ID/Policy No:	Group Name / No:	

PATIENT AUTHORIZATION / RELEASE OF INFORMATION

I hereby authorize CHANTILLY FAMILY PRACTICE CENTER to apply for benefits to my primary insurance company ___________________________ and co-insurance company _______________________ on my behalf for services rendered and that payments be made directly to CHANTILLY FAMILY PRACTICE CENTER. I certify that all the information I have reported is correct and further authorize the release of any necessary information including medical information for processing any related claim by the above named billing agent CHANTILLY FAMILY PRACTICE CENTER. I permit a copy of this authorization to be used in place of the original. The policy holder(s) may revoke this authorization at any time in writing.

Signature ______________________ Date ______________________

POLICY CONCERNING MEDICAL BILLS

Our policy is co-payment to be made at the time services are rendered unless other arrangements are made, any unpaid amounts are due within thirty (30) days of treatment. Payment is accepted in the form of cash, check, money order or credit card. There is a $25.00 service fee for returned checks. I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all claims for myself or the patient named above.

Signature ______________________ Date ______________________