Pulmonary Associates, LTD

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Patient Registration
Please Print Clearly

5216 Dawes Ave
Alexandria, VA 22311
Office: 703-931-4746
Fax: 703-931-1794

First	Middle	Last		Date of Birth

Home Address	Apt#	City	State	Zip Code

Occupation	Marital Status	Social Security #	Home Phone	Sex

Employer	Address	Work Phone

Email Address	Cell Phone	Preferred Method of Contact

Referring/ Consulting Physician	Pharmacy Name, Address and Phone #	Language	Race
		Hispanic? Y N	

Emergency Contact Information

Name of Contact Person	Relationship	Home Phone	Work or Cell Phone

Responsible Party for Billing

Self	Spouse/Parent	Home Address	City/State	Zip Code

Primary Insurance

Insurance Company Name	Identification of Policy Number	Group/Code	Date Effective

Subscriber's Name	Subscriber's Date of Birth	Relation to Patient

Subscriber's Address	Subscriber's Home Phone	Subscriber's Work/Cell Phone

Secondary Insurance

Insurance Company Name	Identification of Policy Number	Group/Code	Date Effective

Subscriber's Name	Subscriber's Date of Birth	Relation to Patient

Subscriber's Address	Subscriber's Home Phone	Subscriber's Work/Cell Phone

Payment is due at the time of service. Patients who do not have insurance or who are in an insurance program with which we do not participate are expected to PAY IN FULL at the time of service and may be asked to pay prior to services being rendered. If we participate with your insurance, all co-pays are due at the time of service and you are responsible for any unpaid balance withing 15 days of being billed. Any disputes regarding insurance payments should be addressed with your insurance carrier. Interest rate for balances over 60 days is 18% per annum and return check fee is $30.00. We reserve the right to charge a $30.00 no show fee if you fail to provide 24 hours notice of cancellation.

I authorize Pulmonary Associates, LTD to apply for benefits on my behalf for services rendered and authorize all payments to be made directly to Pulmonary Associates, LTD. I authorize the release of all Medical or other information necessary process these claims.

I understand that should my account require collections due to non-payment, I am responsible for all collection and attorney fees. I agree to promptly pay all charges for medical services rendered and accept legal responsibility for all charges for the patient named above,

Signature	Date