



915 TOLL HOUSE AVE  
SUITE 101  
FREDERICK, MD 21701  
240-529-1414

DOCTORS VASCULAR  
LABORATORY

BILLING OFFICE:  
301-330-7133

TAX ID: 52-1083816

9715 MEDICAL CENTER DR  
SUITE 105  
ROCKVILLE, MD 20850  
301-762-0277

18109 PRINCE PHILIP DR  
SUITE 100  
OLNEY, MD 20832  
301-762-0277

14201 LAUREL PARK DR  
SUITE 102A  
LAUREL, MD 20707  
240-547-5074

**PATIENT INFORMATION Please print clearly. ALL INFORMATION must be filled in completely in order to file your claim!**

PATIENT NAME			FIRST	MIDDLE	LAST	DATE OF BIRTH	AGE
HOME ADDRESS					CITY	STATE	ZIPCODE
EMPLOYER			SOCIAL SECURITY #		MARITAL STATUS S M D W	SEX	HOME PHONE
OCCUPATION			WORK PHONE			CELL PHONE	
SPOUSE'S NAME (OR PARENT)			SPOUSE'S WORK PHONE (OR PARENT)			SPOUSE'S CELL PHONE (OR PARENT)	
SPOUSE OR PARENT'S ADDRESS, IF DIFFERENT FROM ABOVE							
PHARMACY NAME AND CITY			PHARMACY PHONE NUMBER		PATIENT E-MAIL ADDRESS		
NEAREST RELATIVE/FRIEND (NAME), RELATIONSHIP, and PHONE NUMBER							
RACE			ETHNICITY			LANGUAGE	
PRIMARY CARE PHYSICIAN			ADDRESS			TELEPHONE	
REFERRING PHYSICIAN			ADDRESS			TELEPHONE	

**POLICY CONCERNING PAYMENT OF MEDICAL BILLS**

Our policy is that payment be made at the time services are rendered. Whether or not your insurance pays in full, a portion, or nothing at all for services rendered, is a matter between you and your insurance carrier. Any unpaid balances are due within 30 days of treatment date, unless other arrangements have been made. Payment is expected in the form of cash, check, money order, or credit card. We reserve the right to assess interest at a rate of 1.5% per month on any unpaid balance more than 60 days from the date of service.

I agree to promptly pay all charges when billed for medical services rendered. I know that I am legally responsible for any and all charges incurred for the patient named above.

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Sign

**\*BILLING AND INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY NAME				ID OR POLICY NUMBER		GROUP/CODE	
PRIMARY INSURANCE COMPANY ADDRESS				SUBSCRIBERS SOCIAL SECURITY		DATE EFFECTIVE	
SUBSCRIBERS NAME		FIRST	MIDDLE	LAST	HOME PHONE	RELATIONSHIP TO PATIENT	
SUBSCRIBERS ADDRESS				WORK PHONE		SUBSCRIBERS DATE OF BIRTH	
SECONDARY INSURANCE COMPANY NAME				ID OR POLICY NUMBER		GROUP/CODE	
SECONDARY INSURANCE COMPANY ADDRESS				SUBSCRIBERS SOCIAL SECURITY		DATE EFFECTIVE	
SUBSCRIBER'S NAME		FIRST	MIDDLE	LAST	HOME PHONE	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS				WORK PHONE		SUBSCRIBER'S DATE OF BIRTH	

**PATIENT'S AUTHORIZATION**

I hereby authorize Horizon Vascular Specialists and/or Doctors Vascular Laboratory to apply for benefits on my behalf for covered services provided to me. I request from the insurance company(ies) listed above be made directly to Horizon Vascular Specialists and/or Doctors Vascular Laboratory. I certify that the information I have provided with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this and any related claim, to the above named billing agent (or in case of Medicare Part B benefits, to the Social Security Administration and the Center for Medicare and Medicaid Services). I permit a copy of this authorization to be used in place of the original. The authorization may be revoked in writing. I request that payment of authorized Medigap benefits (when applicable) be made directly to Horizon Vascular Specialists and/or Doctors Vascular Laboratory.

PATIENT ACCOUNT NO:

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Signature of Subscriber or Beneficiary Date