

HORIZON **VASCULAR SPECIALISTS**

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

DOCTORS VASCULAR
LABORATORY

CENTER FOR VENOUS
DISORDERS

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. We cannot file a claim for you if * information is not complete!

*PATIENT NAME FIRST MIDDLE LAST			*DATE OF BIRTH	AGE
*HOME ADDRESS		*CITY	*STATE	*ZIPCODE
OCCUPATION	*SOCIAL SECURITY #	MARITAL STATUS S M D W	SEX	HOME PHONE
EMPLOYER	ADDRESS		WORK PHONE/CELL PHONE	
SPOUSE'S NAME (OR PARENT)	SPOUSE'S EMPLOYER (OR PARENT)		SPOUSE'S WORK PHONE (OR PARENT)	
SPOUSE OR PARENT'S ADDRESS, IF DIFFERENT FROM ABOVE				
NEAREST RELATIVE/FRIEND (NAME)	RELATIONSHIP	HOME PHONE	WORK PHONE	
*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.

Sign

***BILLING AND INSURANCE INFORMATION**

*INSURANCE COMPANY NAME	*ID OR POLICY NUMBER	*GROUP/CODE
*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
*MEDIGAP INSURANCE COMPANY NAME	*ID OR POLICY NUMBER	*GROUP/CODE
*MEDIGAP 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

Medicare Patients Only

PATIENT'S AUTHORIZATION

I hereby authorize Horizon Vascular Specialists, Doctors Vascular Laboratory and/or Center for Venous Disorders 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, Doctors Vascular Laboratory and/or the Center for Venous Disorders. 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, Doctors Vascular Laboratory and/or Center for Venous Disorders.

Signature of Subscriber or Beneficiary Date

PATIENT P-1 ACCOUNT
PATIENT P-2 ACCOUNT
