WOODBURN ENDOSCOPY CENTER

3301 WOODBURN ROAD SUITE 109
ANNANDALE, VA 22003

PATIENT INFORMATION

NAME: (*First, Middle and Last*) _____ DATE OF BIRTH: _____

STREET ADDRESS:
_____CITY_____STATE_____ZIP_____
HOME PHONE: ( )_____ **May leave detailed message____ OR Call back # only ____** **(CHECK**
WORK PHONE: ( )_____ **May leave detailed message____ OR Call back # only ____** **ONE**
CELL PHONE: ( )_____ **May leave detailed message ____OR Call back # only ____** **PLEASE)**
SEX: ☐*MALE* ☐ *FEMALE* OCCUPATION: _____

REFERRING PHYSICIAN/PRIMARY DOCTOR: _____PHYSICIAN'S PHONE: (____)_____

EMERGENCY CONTACT

NAME: _____RELATIONSHIP TO PA TIENT:_____

STREET ADDRESS:
_____CITY_____STATE_____ZIP_____
HOME PHONE: ( )_____ **May leave a detailed message ____ OR Call back # only ____** **(CHECK**
WORK PHONE: ( )_____ **May leave a detailed message ____ OR Call back # only ____** **ONE**
CELL PHONE: ( ) _____ **May leave a detailed message ____ OR Call back # only ____** **PLEASE)**

INSURANCE INFORMATION

***** ***PRIMARY INSURANCE PLAN INFORMATION (MUST BE COMPLETE):*** *****

PLAN NAME: _____ PHONE NUMBER: (__ _)_____

ID #: _____ GROUP #: _____
POLICY HOLDER: _____ HOLDER'S DATE OF BIRTH: _____
RELATIONSHIP: _____
EMPLOYER'S NAME: _____ EMPLOYER'S PHONE: (____)_____

***** ***SECONDARY INSURANCE PLAN INFORMATION:*** *****

PLAN NAME: _____ PHONE NUMBER: (___)_____

GROUP #: _____ POLICY #: _____
POLICYHOLDER: _____ HOLDER'S DATE OF BIRTH: _____
RELATIONSHIP: _____

In an effort to provide outstanding patient care, the physicians of Woodburn Endoscopy Center have built this facility devoted entirely to endoscopy. This unit is a distinct business entity from that of the physicians' practice. As such, your insurance will be billed separately for the services provided at this facility. You may receive up to (4) four separate bills associated with this visit 1) your physician 2)endoscopy center 3)Pathology and 4) anesthesia. All professional services are charged to the patient. We will complete the necessary forms for you insurance carrier, both primary and secondary. Any remaining balance after receipt of the explanation of benefits from your insurances will be billed to you.

This is authorization for Woodburn Endoscopy Center to apply for benefits on my behalf and receive any payments for medical services rendered to me by employees of this organization through all insurance plans indicated above or any other plans through which I man receive coverage. I further authorize the release of any necessary medical information for any claim to my insurance carrier or any medical facility to ensure continuity of care. I hereby acknowledge that I am fully responsible for payment of the total bill incurred and warrant that I shall comply with all insurance plan guidelines to ensure coverage of services provided. In the event that I do not comply with my insurance plan requirements to obtain authorizations, I understand that I will have sole liability for reimbursement of services provided by Woodburn Endoscopy Center. In the event that a collection agency becomes involved due to non-payment, I understand that I am responsible for any and all collection and/or legal fees.

SIGNATURE: _____ DATE: _____

PATIENTS' RIGHTS AND PRIVACY PRACTICES

_____**(Please initial) I have been offered a copy and an explanation of the Patients' Bill of Rights**
_____**(Please initial) I have been offered a copy and an explanation of the Notice of Privacy Practices**
_____**(Please initial) I have been informed that Woodburn Endoscopy Center does not honor Advanced directives or Living Wills.**

REV: 03/08 (D)