Capital Women's Care Ballston-Arlington

4040 N. Fairfax Drive
Suite 801
Arlington, VA 22203

CAPITAL WOMEN'S CARE DIVISION 67 BALLSTON

PATIENT REGISTRATION FORM

Date:_____ Patient Name:_____

DOB:_____ Address:_____

Gender:_____ _____

Social:_____ _____

Preferred Contact Phone: _____

Email: _____

Primary Insurance: _____

ID Number: _____

Policy Holder Name and DOB:_____

Secondary Insurance: _____

ID Number: _____

Policy Holder Name and DOB:_____

Dr. Gwendolyn Cobbs Dr. Danielle Holmes Mary DiMasi, CNM Dr. Sali Jordan

www.capitalwomenscareobgyn67.com

571-970-6050 main 571-970-6352 fax

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Financial Responsibility Policy

I certify that the information I have provided regarding my insurance coverage is correct and I authorize Capital Women's Care to verify insurance coverage and benefits allowed in accordance with my insurance plan's coverage.

I authorize that the payments be made directly to Capital Women's Care for all medical insurance benefits which are payable under the terms of my insurance policy for services provided. I agree to pay any copayment, coinsurance, or deductible as required by my insurance for the terms and regulations of my insurance plan.

Capital Women's Care may impose a no-show fee of $35.00 for appointments not cancelled 24-hours in advance. Capital Women's Care may impose reasonable interest, late charges, direct collection costs (25%) and or reasonable attorney's fees should my account become delinquent. There will be a $40.00 fee assessed for all returned checks.

Payment in Full at Time of Service

I understand that if Capital Women's Care does not participate with my insurance or I do not have insurance, payment is due in full at the time of service.

Release of Medical Information for Billing

I hereby authorize Capital Women's Care to submit a claim and a copy of medical records related to such services, to my insurance company, health and welfare fund, Medical or Medicaid for medical services provided to me or my dependent. I also authorize Capital Women's Care to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Capital Women's Care to release medical information to my consulting or primary physician o assist with continuity of care. This release will expire one year from the date my signature below, unless I cancel this release in writing prior to that date.

Receipt of Privacy Notice

I have been given the opportunity to review the Capital Women's Care Notice of Privacy Practices which provides a detailed description of how my Protected Health information PHI is used and disclosed.

Non-Covered Services

I agree to pay for medical services provided to me or my dep1mdant which are not covered by the benefits in my insurance plan.

Patient Signature: _____ Date: _____

Dr. Gwendolyn Cobbs Dr. Danielle Holmes Dr. Reepa Shah

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