1145 NINETEENTH STREET, N.W.
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292-223-8600
FAX 202-828-9376

PETER E. LAVINE, M.D.

2616 SHERWOOD HALL LANE
SUITE 300
ALEXANDRIA, VA 22306
703-799-3889
FAX 703-780-6663

GENERAL INFORMATION

Patient's Name _____ (First / Middle / Last) Age _____ Date of Birth _____ (Mo. / Day / Year)

Patient's Address _____ (Street) (Apt. #)

_____ (City / State / Zip) Phone _____

Soc. Sec. No. _____ Sex _____ Marital Status _____

Patient's Occupation _____ Employed by _____

Employer's Address _____ (Street / Suite # / City / State / Zip) Phone _____

Who is responsible for this bill? _____ Relationship _____

Responsible Party's Address _____ (Street / Suite # / City / State / Zip) Phone _____

Soc. Sec. No. _____

Responsible Party's Occupation _____ Employed by _____

Employer's Address _____ (Street / Suite # / City / State / Zip) Phone _____

Notify in case of emergency _____ Relationship _____ Phone _____

INSURANCE INFORMATION

DO YOU HAVE HEALTH INSURANCE? ❑ Yes ❑ No *(If yes, please complete the following)*

Primary Insurance Carrier or Medicare _____

Policy No. (Contract No.) _____ Group No. _____ Service Code _____

Insurance Company Address _____ (Street / Suite # / City / State / Zip) Phone _____

Name of Policy Holder _____ D.O.B. _____ Relationship _____

Secondary Insurance Carrier _____

Policy No. (Contract No.) _____ Group No. _____ Service Code _____

Insurance Company Address _____ (Street / Suite # / City / State / Zip) Phone _____

Name of Policy Holder _____ D.O.B. _____ Relationship _____

Medicaid (Medical Assistance) No. _____ State _____ Expiration Date _____

INJURY - AUTOMOBILE ACCIDENT

Date of Accident _____ Time _____ AM / PM Driver ❑ Passenger ❑ Are you covered by PIP (no fault) insurance? ❑ Yes ❑ No

State _____ Claim No. _____

Name of your Insurance Carrier _____ Phone _____

Address _____ (Street / Suite # / City / State / Zip)

INJURY - WORKMAN'S COMPENSATION (INJURED ON THE JOB)

Date of Injury _____ Claim/File No. _____ State _____

Compensation Insurance Co. Name _____

Insurance Co. Address _____ (Street / Suite # / City / State / Zip) Phone _____

Employer at time of injury _____ Employers Phone _____

Was injury reported to supervisor? ❑ Yes ❑ No Name of Supervisor _____

INJURY - OTHER THAN ON THE JOB OR AUTOMOBILE

Date of Injury _____ Where did it occur? _____

How did it occur? _____

COMPLETE IF AN ATTORNEY IS REPRESENTING YOU FOR YOUR INJURY

Attorney's Name _____ Phone _____

Attorney's Address _____

Patient Account # _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM, THANK YOU.

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Patient's Authorization

I,_____, hereby authorize Peter E. Lavine, M.D. to apply for benefits on my behalf for covered services rendered by Peter E. Lavine, M.D. I request that payment of authorized Medicare benefits and BC/BS of the National Capital Area, Blue Shield of Maryland, &/or _____
(other ins. co. name)
be made directly on my behalf to Peter E. Lavine, M.D., for any services furnished to me by that physician or supplier.
I certify that the information. I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this or any related claim, to BC/BS of the National Capital Area the above named billing agent, Blue Shield of Maryland (or in case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) &/or_____. I, also hereby assign to
(other ins. co. name)
Peter E. Lavine, M.D., all payments for medical services rendered to myself and/or my dependents. I understand that I am financially responsible for all charges (including equipment and/or supplies) not covered by this assignment (whether or not paid by said insurance). There will be a 30% attorney fee, if referred for collections. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

Signature of Subscriber or Beneficiary	Identification No.	Date

BILLING AND PAYMENT PROCEDURES

Payment is requested at the time services are rendered. All professional services rendered are charged to the patient and the patient is responsible. Our staff will assist you in completing any forms necessary to expedite reimbursement from insurance carriers at no additional charge. If person, other than patient, patient's spouse or parent, has accepted financial responsibility for medical bills, and signed consent to that effect must be on file. Our staff will gladly explain or assist you with any aspect of this policy.

THANK YOU FOR THIS INFORMATION

Insurance Waiver

I hereby agree and understand that liability/automobile/personal injury claims may not be covered completely by traditional health or supplemental insurance policies and these charges are my sole responsibility for payment in full, regardless of the outcome of the legal remedy. In instances where my third party payer pays a portion of my bill for these services rendered, I agree to waive my contractual relationships with third party payers and accept responsibility to pay the balance owed.

I hereby agree and understand that some services and/or supplies may not be covered or reimbursed by my insurance carrier. It is my understanding that these services/supplies, which are not covered/reimbursed, will be billed to me and these charges are my sole responsibility for payment in full. I further agree that the said balance will be paid in full within 30 days of my being billed by the office of Peter E. Lavine, M.D. I also understand that I may purchase any supplies (Durable Medical Goods) elsewhere p rior to the disbursement of these supplies by this office, but have chosen to purchase these items from the office of Peter E. Lavine, M.D.

Sign your name	Date

Patient Account #_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM, THANK YOU.