Wendy Gottlieb, M.D.

1850 Town Center Drive #301 Reston, VA 20190

PATIENT REGISTRATION **MAY WE SEND YOU INFORMATION ____YES ___ NO**

Patient Name: First **M.I.** **Last** **Male/Female**? M or F **Social Security** **Date of Birth**

Home Address **APT#** **City** **State** **Zip** **Home Phone**

Employer Address **Work Phone**

Occupation **Referred by**: First and Last Name **Cell Phone**

How did you hear about us? **Physician**: First and Last name & Phone **Email:** **Marital Status** ___S___M___W___D

Spouses Name Work Phone Occupation

Person to contact in case of Emergency(Relationship) Telephone

May we leave a message(please circle all that apply)
Home **Work** **Cell**

May we discuss your medical condition with any member of your family?
(If yes whom?)

Primary Insurance Billing Information

Ins. Co. Name: ________________________________

Address: ______________________________________

City, State & Zip:
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I.D. No.: ______________________________________

Group Name: ________________ Group # __________

Subscriber: ____________________________________

Subscribers Date of Birth: ________________________

Subscriber's Social Security:

Secondary Insurance Information

Ins. Co. Name: ________________________________

Address: ______________________________________

City, State & Zip:________________________________

I.D. No. : ______________________________________

Group Name: __________________Group #_________

Subscriber: ____________________________________

Subscribers Date of Birth: ________________________

Subscriber's Social Security :

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payment. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for service when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections. I will pay any fees/costs incurred during the collection process. **There is a charge for any forms that need to be filled out for work or disability. This fee will range from $10.00 to $50.00.**

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Wendy Gottlieb, M.D. to furnish information to my insurance carriers(including Medicare/medigap) concerning my illness and treatments and hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

I acknowledge that I have been offered a copy of the privacy notice of Dr. Wendy Gottlieb, M.D. **Copy taken ____ Declined____**

Date: ***Signature of Patient/Guardian***

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