

Pulmonary Associates, LTD

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Patient Registration
Please Print Clearly

5216 Dawes Ave
Alexandria, VA 22311
Office: 703-931-4746
Fax: 703-931-1794

First	Middle	Last	Date of Birth	
Home Address	Apt#	City	State	Zip Code
Occupation	Marital Status	Social Security #	Home Phone	Sex
Employer	Address		Work Phone	
Email Address	Cell Phone		Preferred Method of Contact	
Referring/ Consulting Physician	Pharmacy Name and #	Language		Race
		Hispanic?	Y	
Emergency Contact Information				
Name of Contact Person		Relationship	Home Phone	Work or Cell Phone
Responsible Party for Billing				
Self	Spouse/Parent	Home Address	City/State	Zip Code
Primary Insurance				
Insurance Company Name		Identification of Policy Number	Group/Code	Date Effective
Subscriber's Name		Subscriber's Date of Birth	Relation to Patient	
Subscriber's Address		Subscriber's Home Phone	Subscriber's Work/Cell Phone	
Secondary Insurance				
Insurance Company Name		Identification of Policy Number	Group/Code	Date Effective
Subscriber's Name		Subscriber's Date of Birth	Relation to Patient	
Subscriber's Address		Subscriber's Home Phone	Subscriber's Work/Cell Phone	

Payment is due at the time of service. Patients who do not have insurance or who are in an insurance program with which we do not participate are expected to PAY IN FULL at the time of service and may be asked to pay prior to services being rendered. If we participate with your insurance, all co-pays are due at the time of service and you are responsible for any unpaid balance within 15 days of being billed. Any disputes regarding insurance payments should be addressed with your insurance carrier. Interest rate for balances over 60 days is 18% per annum and return check fee is \$30.00. We reserve the right to charge a \$30.00 no show fee if you fail to provide 24 hours notice of cancellation.

I authorize Pulmonary Associates, LTD to apply for benefits on my behalf for services rendered and authorize all payments to be made directly to Pulmonary Associates, LTD. I authorize the release of all Medical or other information necessary process these claims.

I understand that should my account require collections due to non-payment, I am responsible for all collection and attorney fees. I agree to promptly pay all charges for medical services rendered and accept legal responsibility for all charges for the patient named above,

Signature	Date
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