Old Dominion Medical Center

6715 Whittier Avenue Suite 100, Mclean VA. 22101

Registration Form

Allen B. Horne, MD Patricia Leighton, NP

Patient Information					
First Name:	M.I.	Last Name:			Social Security #:
Street Address:		City:	State:		Zip Code:
Home Phone #:	Date of Birth: (MMDDYYYY)	Sex: M / F	Marital Status (circle one) Single / Married / Divorced / Separated / Widowed		
Employer:	Address:		City:	State:	Zip Code:
Occupation:	Work Phone:	Work Status (circle one) FT / PT / Retired	Email:		
Preferred Pharmacy:	Designated Individual to share my protected information with:	Relationship with Designated Individual:	Designated Individual's Contact Information Including Email:		

Guarantor Information (Responsible Party)					
First Name	M.I.	Last Name:			Social Security #:
Address (if different from above):		City:	State:		Zip Code
Home Phone:	Work Phone:	Relationship to Patient:			
Emergency Contact First Name:	Emergency Contact Last Name:				Phone Number:

Payment & Insurance Information (Please provide us with a copy of your insurance card)			
Primary Insurance:	Type: Individual / Group / Medicaid / Medicare / Other		Co-payment: $
Policy Number:	Group/Plan Number:	Subscriber Name: Date of Birth: Relationship to Subscriber: Self / Spouse / Child / Parent / Other:	
Secondary Insurance:	Type: Individual / Group / Medicaid / Medicare / Other		Co-payment: $
Policy Number:	Group/Plan Number:	Subscriber Name: Date of Birth: Relationship to Subscriber: Self / Spouse / Child / Parent / Other:	

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carried payments. The patient is responsible for all other fees, regardless of insurance coverage. Payment is due when services are rendered unless other arrangements have been made in advance with our office. You agree to reimburse provider the fees of any collection agency, which may be based on a percentage at a maximum of 28% of the debt, which fee shall be added at the time of placement with the collection agency, and all costs, and expenses, including reasonable attorney's fees we incur in such collection efforts.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Old Dominion Medical Center, P.C. to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I 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.

_____ _____

Signature of Subscriber or Beneficiary Date

Old Dominion Medical Center

6715 Whittier Avenue Suite 100, Mclean VA. 22101

Registration Form

Allen B. Horne, MD Patricia Leighton, NP

I acknowledge that I have been offered a copy of the privacy notice of Old Dominion Medical Center, P.C. Copy Taken ____ Copy Declined_____

_____ _____

Signature of Patient Date