

Fairfax Colon and Rectal Surgery, PC
REGISTRATION FORM
(PLEASE PRINT)

Today's Date:

PATIENT INFORMATION

Patient's Last Name:			First:	Middle:	Marital status:	
					Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Birth Date:	Age:	Sex:		Home Phone No.:		
		MALE FEMALE				
Street Address:			Social Security no.:		Cell Phone No.:	
City:	State:	Zip Code:		Email Address:		
Occupation:	Employer:			Work Phone No.:		
				()		
Name of Referring Doctor:			Primary Care Doctor:			
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):		Home phone no.:		
				()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.:	
					()	
Is the patient employed: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:	
					\$	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Fairfax Colon and Rectal Surgery, PC, or insurance company to release any information required to process my claims. Due to the high volume of patients in our practice, we may charge a missed appointment fee if you do not cancel your office visit more than 1 business day in advance.

Patient/Guardian signature

Date

FAIRFAX COLON & RECTAL SURGERY, P.C. and L.L.C.

DONALD B. COLVIN, M.D., F.A.S.C.R.S.

PAUL E. SAVOCA, M.D., F.A.S.C.R.S.

LYNDA S. DOUGHERTY, M.D., F.A.S.C.R.S.

DANIEL P. OTCHY, M.D., F.A.S.C.R.S.

LAWRENCE E. STERN, M.D. F.A.S.C.R.S.

JOSEPH C. MULLER, M.D., F.A.C.S.

COLORECTAL/ANORECTAL SURGERY, COLONOSCOPY, ANORECTAL PHYSIOLOGY

The Healthcare Industry is experiencing a dramatic increase in the cost of malpractice insurance in the state of Virginia. At the same time, reimbursement from insurance companies continues to decline. We now find it necessary to institute several changes in our office policies. We appreciate your cooperation and understanding while we endeavor to provide you with the best possible medical care. For your convenience, we accept cash, checks, money orders, and most credit cards.

ARRIVAL TIME: Please arrive 15 minutes before your scheduled appointment time in order to complete the paperwork necessary for your visit. This will help us to keep to the scheduled appointment times. Updating paperwork is required for every visit to the office.

MISSED APPOINTMENTS: \$50.00. Missed office appointments are appointments cancelled with less than 24 hours notice. Missed procedure/surgical appointments will incur a \$200.00 charge with less than a 7 day notice of cancellation. Abusive missed appointments may result in your dismissal as a patient.

RESCHEDULING: Because we are a surgical practice, emergency situations may arise that result in the physician being called away to an operating room. As a result, your appointment may need to be rescheduled or the physician may run late. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is a \$10.00 processing fee, plus \$0.50/page. These fees, set forth by Virginia State law, must be paid in full before your request can be processed. Please allow two weeks for processing.

FORMS, LETTERS, REPORTS: Disability, workman's compensation, etc... The fee for completion of these items is \$35.00. All fees must be paid in full before the forms can be produced. Please allow at least one week for processing.

PRESCRIPTIONS: If for any reason your prescription for medication, CT Scan, MRI, PET scan, etc., needs to be rewritten there will be a \$10.00 charge for a replacement to be called or faxed to a pharmacy, radiologist, or mailed to you.

FINANCIAL RESPONSIBILITY: Please note, because the insurance policy is an agreement between you and your insurance company, we expect all patients or their guardian to be fully responsible for knowledge of your insurance benefits, as well as fully and directly responsible for all charges regardless of insurance coverage. Please be assured that we will do everything possible to see that you receive your full benefits in a timely manner. If your insurance company has not paid their portion within 60 days, you will be responsible for full payment at that time.

COLLECTIONS: I understand that in the event my account becomes past due (over 30 days) and all attempts to arrange payment have failed, my account may be placed for collection. I also understand that I will be responsible for all cost of collection including agency fees, court cost and/or attorney fees in the amount of 33.33% of the outstanding balance.

COPAY AND COINSURANCE: Where we have a participating agreement with your insurance company, we will expect your estimated co-payment and/or co-insurance at the time of treatment.

NO INSURANCE: Payment in full is due at the time of treatment. Payment plans may be arranged with our billing director.

NON PARTICIPATING INSURANCE: We will file with your insurance company as a courtesy. However, you will be responsible for all charges not covered by insurance.

OUTSTANDING BILLS: There will be a 1.5% finance charge (18% annually) per payment period for balances not paid within 60 days, unless other arrangements have been made.

RETURNED CHECK FEE: \$35.00 for each check returned for insufficient funds.

I have read and understand the foregoing.

Patient signature or authorized person: _____

Date: _____