FOXHALL MEDICINE, P.L.L.C.

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PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SOCIAL SECURITY # _____

ADDRESS CONTINUED: _____ HOME PHONE: _____

REFERRING PHYSICIAN: _____ CELL # _____

PREFERRED PHARMACY: _____ WORK # _____

_____

We are required to obtain the following information in order to be compliant with the Federal Regulations:
Race: Caucasian___ Black___ Hispanic ___ Asian___ Native American___ Asian Pacific American___
Pacific Islander___ Subcontinent Asian American___ American Indian or Alaskan Native___
Native Hawaiian___ Black Non-Hispanic___ White Non-Hispanic___ Other Race___ More than One Race___
Not Reported - Refused___ Not Reported - Unknown___

Ethnicity: Latino/Hispanic___ Other___ Not Reported - Refused___

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

FINANCIAL POLICY

DR. THOMAS IS OUT OF NETWORK OR "NON-PARTICIPATING" WITH ALL INSURANCE CARRIERS, INCLUDING MEDICARE. OUR BILLING DEPARTMENT WILL SUBMIT CLAIMS TO YOUR INSURANCE COMPANY ON YOUR BEHALF. PAYMENT FOR ALL SERVICES IS EXPECTED AT THE TIME OF SERVICE.

- ALL UNPAID BALANCES OVER 60 DAYS ARE SUBJECT TO A RE-BILL CHARGE OF $25.00.
- ANNUAL PHYSICAL APPOINTMENTS NOT CANCELLED WITH AT LEAST 24 HOURS NOTICE ARE SUBJECT TO A $350.00 MISSED APPOINTMENT CHARGE.
- ANY BALANCE OVER 90 DAYS OUTSTANDING MAY BE FORWARDED TO A COLLECTION AGENCY. YOU AGREE TO REIMUBURSE ANY FEES FROM THE COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 50% OF THE ACCOUNT BALANCE, IN ADDITION TO ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEY'S FEES THAT THE OFFICE INCURS DURING THESE COLLECTION EFFORTS.
- ALL RETURNED CHECKS WILL BE CHARGED A $35.00 INSUFFICIENT CHARGE FEE.
- OUR OFFICE DOES NOT BILL SECONDARY CLAIMS FOR DR. THOMAS' PATIENTS SINCE WE DO NOT RECEIVE THE PRIMARY INSURANCE EOB.

I HEREBY AUTHORIZE THE OFFICE OF FOXHALL MEDICINE TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I UNDERSTAND THAT THIS IS DONE AS A COURTESY AND ALL CHARGES MUST BE PAID AT THE TIME OF SERVICE.

PATIENT SIGNATURE: _____ DATE: _____