

SCOTT A. MCNAMARA, M.D., F.A.C.S.

BOARD CERTIFIED OTOLARYNGOLOGY-HEAD AND NECK SURGERY
BOARD CERTIFIED AMERICAN ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY
FELLOW OF THE AMERICAN COLLEGE OF SURGEONS

NEW PATIENT INFORMATION

Patient Name _____ PT#: _____
Last First Middle

Address _____
Street Address City State Zip

Home Phone# _____ Work Phone# _____
Cell Phone# _____ FAX# _____

Sex: Female Male D.O.B. _____ Marital Status _____ Social Security # _____

Employer's Name _____

Employer's Address _____

Occupation: _____ E-Mail Address: _____

Nearest Relative (Emergency Contact)

Name _____
Last First Middle

Address _____
Street Address City State Zip

Home Phone# _____ Work Phone# _____ Relationship _____

Primary Care Physician Name _____ Phone# _____

How did you hear about us:

Referring Physician Name _____

Friend/Relative Name _____

Financial Information:

Who is responsible for this bill? _____

I will be paying today by: CASH CHECK VISA/MASTER CARD

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

POLICY NO/MEMBER NO. _____ GROUP NO. _____

SUBSCRIBER'S NAME _____ RELATIONSHIP _____

SUBSCRIBER'S ADDRESS _____

SUBSCRIBER'S EMPLOYER AND ADDRESS _____

SUBSCRIBER'S SOCIAL SECURITY # _____ DATE OF BIRTH _____

SUBSCRIBER'S DAY-TIME PHONE _____

I authorize The Washington Medical Group/Scott A. McNamara, M.D. to apply for benefits on my behalf for medical services rendered by him or his associates. I request and authorize payment from my insurance company be made directly to The Washington Medical Group/Scott A. McNamara, M.D. I certify that all information recorded above is completely accurate. I understand my insurance coverage is an agreement between the insurance carrier and myself, and that I will be fully liable for charges on my account. I understand that I will be responsible for payment for any services rendered which are not covered by my insurance plan(s). I agree to pay any deductibles and co-pays at the time services are rendered. I understand that once the office of The Washington Medical Group /Scott A. McNamara, M.D. sends me a statement of my account ("patient bill"), I have 30 days to pay before my balance starts to accrue interest at a rate of 21% per annum. Should I default on the payment of my account, I agree to be responsible for charges accrued related to the collection of my account balance.

I authorize the release of any necessary information, including medical information for this or any related claim to my insurance company. A copy of this authorization is to be considered as valid as the original.

Patient/Guardian Signature

Date

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INSURANCE WAIVER

Due to continually changing rules regarding insurance coverage, it has become essential to ask you to read and sign this Insurance Waiver prior to your visit with the physician and prior to our billing your insurance company.

As a courtesy, we will process your insurance for you. At the time that medical service is rendered today, you are responsible for any deductible and any copay amounts.

Once we have received an "EOB" (Explanation of Benefits) from your insurance company, we will review it to see if they paid the claim in full. If they have denied partial or full payment for any reason, you are responsible for paying the balance due.

If you have not paid the balance within 30 days, a service charge equal to 21% per annum on the balance due (minimum service charge \$5.00) will be accrued.

I have read and understood this Insurance Waiver.

Signature

Date

Patient Name

Pt Number

