Champlain Ophthalmology, Chartered

6430 Rockledge Drive, Suite 270, Bethesda, Maryland 20817
(301) 493-9600

A Demographic Information

Patient Name Mr. Mrs. Ms. Dr.	First	Middle	Last	Date of Birth	Age	Sex
Home Address			City	State	Zip Code	
Occupation	Social Security Number		Home Phone	**Cell Phone**		
Employer (or previous if retired)	Address		Work Phone			
Spouse (or parent) Name	Spouse (or parent) Employer		Spouse Phone			
Spouse (or parent) Address						
Allergies			Referred by / How did you hear of us			
		Internist/Primary Care Doctor			Phone	

B Billing and Insurance Information

Send Bill To	First Name	Last Name	Relationship to Patient	Home Phone	Work Phone
	Home Address		City	State	Zip Code
Primary Insurance	Insurance Company Name		ID Number	Group	
	Insurance Company Address				
	Subscriber's Name	Date of Birth	Relationship to Patient		
Secondary Insurance	Insurance Company Name		ID Number	Group	
	Insurance Company Address				
	Subscriber's Name	Date of Birth	Relationship to Patient		

Policy Concerning Payment of Medical Bills: Payment is required at the time of service. For your convenience, we accept cash, check, Visa, AMEX, and MasterCard. Your insurance coverage is a contract between you and your insurance company and it is your responsibility to know the limits and benefits. We will assist your insurance company in processing your claim when necessary; however, you are ultimately responsible for the payment of your account. We will file insurance claims only for the plans in which we participate at any given time. Due to variations in policies, it is your responsibility to check with us and your insurance plan to be sure they consider us as participating providers. As a patient, we will bill your insurance company and be reimbursed directly. You are responsible for refraction fees, contact lens services, co-payments and deductibles at the time of service. If your insurance denies payment for services rendered for any reason, we will bill you and payment is expected within 30 days.

I have read and understand all of the above, authorize Champlain Ophthalmology to bill my insurance carrier, and agree to promptly pay all charges when billed for services rendered. I agree to accept legal responsibility for any and all charges for the patient named above.

X ______________________ **Date / /**