****PLEASE****
****PRINT****

PATIENT LABEL

GOES HERE

M.D. Express Williamsburg

Office Use Only
Acct#:_____

Date: **XX-XX-XXXX**

Paid:$_____
CASH – CK – V – MC – DB – AX – D

Patient Information:

First Name _____ MI ____ Last Name _____ Sex: M / F

Billing Address _____City _____ State _____ Zip Code_____

SS# _____ Date of Birth _____ Age _____ Marital Status: S M D W

Home # _____ Work #_____ Other # _____

Primary Care Physician: _____ Employer: _____

*** Have you ever been treated here before: Y N**
*** Are you a W&M student: Y N**
*** Is this visit for workers comp: Y N**
*** Are you a tourist: Y N**
*** Is this visit for an automobile accident: Y N**
*** E-mail: _____**
*** How did you hear of M.D. Express:**

Responsible Party: (Please complete if different from above.)

Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code_____

SS# _____ DOB _____

IF NO INSURANCE INFORMATION IS OBTAINED AT THE TIME OF SERVICE, THE PATIENT WILL BE CONSIDERED A SELF-PAY AND PAYMENT WILL BE DUE AT THE TIME OF SERVICE.

THE PATIENT IS RESPONSIBLE FOR FEES FOR ALL SERVICES RENDERED, REGARDLESS OF INSURANCE COVERAGE. ALL PAYMENTS ARE DUE WHEN THE SERVICE IS RENDERED. DUE TO CARRIER PROCESSING, WE COLLECT A PCP CO-PAY AT THE TIME OF SERVICE WHEN THERE IS NO URGENT CARE CO-PAY STATED, BUT IF YOUR CARRIER LEAVES A HIGHER COST SHARE, YOU WILL BE BALANCED BILLED. THE PATIENT AND/OR THE PATIENT'S INSURANCE CARRIER MAY RECEIVE A SEPARATE BILL FOR LABORATORY SERVICES AND X-RAY INTERPRETATIONS. THESE PAYMENTS ARE DUE TO THE ENTITY PERFORMING THESE SERVICES. M.D. EXPRESS HAS NO CONTROL OVER THE COSTS OR TERMS OF PAYMENT ASSOCIATED WITH THESE SERVICES.
M.D. EXPRESS CHARGES A $50.00 FEE FOR ANY RETURNED CHECK.

Patient Consent

I consent to the release of protected health information that is required to carry out treatment and payment for healthcare services performed on my behalf. I also consent to all treatments as deemed appropriate by the treating physician and agree to pay for all such services rendered and/or authorize my insurance company to pay M.D. Express directly. I accept responsibility for payment of all charges incurred as well as all collection agency costs and or attorneys fee up to 33 1/3% should such collection action become necessary. I further attest that I have received, read and understand the Notice of Privacy Practices of M.D. Express. I understand that M.D. Express participates in the Virginia Prescription Monitoring program.

We would like to call you after your visit to see how you are doing. Please notify us if it is unacceptable to speak with a family member or leave a message on an answering machine.

_____
Signature

XX-XX-XXXX
Date