DRS. GOUEL AND BLOTNY

ELIAS G. GOUEL, M.D. *KRYSTYNA J. BLOTNY, M.D.* *LOIS B. SULLIVAN, M.D.*

PATIENT REGISTRATION

PATIENTS LAST NAME | PATIENTS FIRST NAME | M.I. | SEX | DATE OF BIRTH

ADDRESS | CITY/STATE/ZIP | HOME PHONE NUMBER

SIBLING LAST NAME | FIRST NAME | M.I. | SEX | DATE OF BIRTH

SIBLING LAST NAME | FIRST NAME | M.I. | SEX | DATE OF BIRTH

SIBLING LAST NAME | FIRST NAME | M.I. | SEX | DATE OF BIRTH

SIBLING LAST NAME | FIRST NAME | M.I. | SEX | DATE OF BIRTH

PARENT INFORMATION

==========PARENT/GUARDIAN==========

LAST NAME | FIRST NAME | DATE OF BIRTH

ADDRESS | CITY/STATE/ZIP

HOME PHONE NUMBER

WORK PHONE NUMBER

CELL PHONE NUMBER

E-MAIL ADDRESS

==========PARENT/GUARDIAN==========

LAST NAME | FIRST NAME | DATE OF BIRTH

ADDRESS | CITY/STATE/ZIP

HOME PHONE NUMBER

WORK PHONE NUMBER

CELL PHONE NUMBER

E-MAIL ADDRESS

INSURANCE INFORMATION

==========PRIMARY INSURANCE==========

INSURANCE COMPANY NAME

POLICY HOLDER'S NAME

POLICY NUMBER | GROUP NUMBER

EFFECTIVE DATE | COPAY AMOUNT

EMPLOYER NAME

==========SECONDARY INSURANCE==========

INSURANCE COMPANY NAME

POLICY HOLDER'S NAME

POLICY NUMBER | GROUP NUMBER

EFFECTIVE DATE | COPAY AMOUNT

EMPLOYER NAME

BILLING & MEDICAL RECORDS AUTHORIZATIONS

BILLING & MEDICAL RECORDS: I authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent and/or insurance company. I hereby authorize Drs. Gouel and Blotny to apply for benefits on my behalf for covered services rendered. I also authorize and request that payment from my insurance carrier(s) be made directly to the above provider. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility & obligation to pay for medical services provided, when a statement is rendered. I authorize the above provider to utilize medical data related to my care for statistical studies.
I **will be responsible for any amount not covered by the insurance, paid toward my deductible, co-insurance or any co-pay amount.**

DIVORCED/SEPARATED PARENT RESPONSIILITY: When one parent is responsible for medical bill payment we can set up the account to bill to that person directly. However, whoever brings the child in for their visit will be responsible for paying any copays or balance owed at that time. We will gladly give a paper bill for the parent to take and give the other parent for reimbursement. **PLEASE PROVIDE COURT DOCUMENTATION**.

NON-PAYMENT OF BALANCE: In the event that an overdue balance is sent to our collection attorney, I understand that I will be responsible for their charge to collect money due the Practice. This fee is 40% of any balance due.

FORMS COMPLETION and MEDICAL RECORDS FEES: I understand that there is a fee of $5.00 per page to complete forms. This fee would be payable prior to taking possession of the forms. : I understand that the Practice follows the Federal guidelines, Health Article 4-304 (c) (3) for preparation and copying fees. These fees must be paid prior to taking possession of the copies.

BILLING COMPANY: Our billing is completed thru Practice Dynamics, Inc. You can call them with all questions at **410.469.4369**.

C0-PAY AND BALANCE DUE: These fees are due at time of service. Please be prepared to pay them. We except cash, credit card (Visa and Master Card) and check. You can also pay your bill on-line by going to **Epay.lifebridgehealth.org** If writing a check and mailing your payment you can mail it to LifeBridge Community Physicians, Inc. P.O. Box 62643, Baltimore, Maryland 21264-2643

MISSED APPOINTMENTS: Should you fail to keep an appointment and have not called us 24 hours prior to the appointment a missed appointment fee of $25.00 will be added to your account.

PLEASE NOTE: It is YOUR RESPONSIBILITY to bring YOUR INSURANCE CARD(S) TO EVERY VISIT, TO PAY YOUR CO-PAY and ANY BALANCE DUE AT TIME OF SERVICE.

Patient or Legal Representative DATE