Patient Registration Form

Name (Last, First, Middle Initial):	Date of Birth:	Age:
Ethnicity: O Caucasian O African-American O Hispanic O Asian O Other:	Social Security#:	Preferred Language:
Address:	City, State, Zip Code:	
Home Phone:	Cell Phone:	
Emergency Contact Name: (Circle relation) Spouse / Parent / Guardian / Friend / Partner	Emergency Contact Phone Number:	
Email Address:		
Primary Care Physician:	Primary Care Physician Phone Number:	
Medical Insurance (please present ID and insurance card to the receptionist)		
Primary Insurance:	Secondary Insurance:	
Insured Party ID#:	Insured Party ID#:	
Group ID#	Group ID#	
Name of Insured and DOB:	Name of Insured and DOB:	

Patient Consent for Treatment

1. I voluntarily consent to all health care treatment and diagnostic procedures provided by Capitol Surgeons and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Capitol Surgeons.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or follow-up reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/ the patient, treatment and health care operations consistent with the Capitol Surgeons Notice of Privacy Practices.
4. I authorize payment of medical benefits to Capitol Surgeons physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

_____ _____

Patient or Authorized Person's Signature Date

8630 Fenton Street ~ Suite 122 ~ Silver Spring, MD 20910
Tel 301-588-0057 | Fax 301-588-0014

Medical History

Patient Name**:** _____ Age: _____ DOB: _____

X-rays or lab work done *within the 6 months*?☐ Yes ☐ No

If yes, location & phone number of facility: _____

For women only: Are you pregnant? ☐Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

IF NOTHING APPLIES, PLEASE WRITE "N/A"

Allergies	Reactions

Past and Current Medical Conditions	Date	Complications?

Past Surgeries and Procedures	Date	Complications?

MEDICATIONS: Please list any vitamins or herbal supplements		
Medication Name	Strength/Dose	Reason for taking

Personal Habits	YES	NO
Do you smoke?		
Do you drink alcohol?		
How many drinks per day/week? _____		

Preferred Pharmacy Information
Name: _____ City: _____
Phone Number:

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Financial Policy and Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements of payment for services provided to patients.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected when you check out.

Insurance Policy

- If you are an insurance patient, it is our policy to file for insurance as a courtesy to you, if we have accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- If we have not received a payment from your insurance company within the contracted time frame specified by your insurance company's contract with Capitol Surgeons, you will be responsible for the balance due.
- Deductibles, co-payments, and coinsurance will be collected before services are rendered.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

Overdue and Credit Balances

- All over-due patient balances will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

Signature: _____ Date: _____

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I hereby authorize Capitol Surgeons, LLC to contact me regarding confidential information, including but not limited to: follow-up calls, lab test results, diagnoses, etc. in the manner described below:

☐ Preferred Phone Number: _____

☐ Preferred Mailing Address: _____

☐ Preferred Email Address: _____

☐ All of the above

☐ Neither; I prefer to receive my confidential information in person

* In order for email communication to occur, please accept the disclosure below:

____ Initial I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.

If you wish to disclose your health information, please designate those individuals below:

☐ I choose to disclose all of my financial and billing information with the following persons:

_____

☐ I choose to disclose all of my medical information with the following person:

_____

☐ Other: _____

☐ I do not wish to disclose any financial or medical information to anyone.

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy I have read this form that serves as an informed consent document and an authorization and have been given the opportunity to ask questions. If I have questions later, I understand I can contact Capitol Surgeons, LLC. I will be given a signed copy of this document for my records. BY COMPLETING AND SUBMITTING THIS FORM, I AGREE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMENTS OF MY INFORMED CONSENT, MY RIGHTS AND RESPONSIBILITIES.

Signature: _____ Date: _____