

Bluepoint Surgical Group

2280 Opitz Blvd Suite 320
Woodbridge, VA 22191
(703) 878-7610

Reason for Visit: _____

PATIENT NAME: FIRST		M.I.	LAST		MALE / FEMALE? M or F		SOCIAL SECURITY #	DATE OF BIRTH	
HOME ADDRESS			APT #	CITY	STATE	ZIP	HOME PHONE		
EMPLOYER		ADDRESS					WORK PHONE		
OCCUPATION				REFERRED BY: FIRST and LAST NAME			CELL PHONE		
ALLERGIES TO MEDICATIONS		PERSONAL PHYSICIAN: FIRST and LAST NAME (Give address and Phone if known)					MARITAL STATUS ___S ___M ___W ___D		
SPOUSES NAME				WORK PHONE:		OCCUPATION			
PERSON TO CONTACT IN CASE OF EMERGENCY (NOT RESIDING WITH YOU)							TELEPHONE		
POLICY HOLDER NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH		FINANCIALLY RESPONSIBLE PERSON ___PATIENT ___SPOUSE ___PARENT ___OTHER			
EMPLOYER		ADDRESS					WORK PHONE		

Primary Insurance Billing Information

Secondary Insurance Billing Information

Ins. Co. Name _____ Address: _____ City, State & Zip: _____ ID.No: _____ Group Name: _____ Group # _____ Subscriber: _____ (Person's Name) Subscribers Date of Birth: _____ Subscriber's Social Security # _____	Ins.Co. Name _____ Address: _____ City, State & Zip: _____ ID.No: _____ Group Name: _____ Group# _____ Subscriber: _____ (Person's Name) Subscriber's Date of Birth: _____ Subscriber's Social Security # _____
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PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/costs incurred during the collection process.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr Halmi and Associates, Inc. to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurances.

I understand that I will be responsible for a charge of \$100.00 for missed appointments without at least 24 hour prior cancellation notice and a charge of \$100.00 for any missed surgery/procedure without at least 48 hour prior cancellation notice; and a \$10 processing fee will be charged if I do not pay my copay at the time of my visit. I certify that the information I provided above is correct.

Date

Signature of Subscriber or Beneficiary

I acknowledge that I have been offered a copy of the privacy notice of Dr. Halmi and Associates, Inc.

Copy Taken ___ Copy Declined ___

Date

Signature of Patient

Email Address _____