☐ WIMC Fair Oaks
12011 Lee Jackson Memorial Hwy
Fairfax, VA 22033

☐ WIMC Burke
6045 Burke Centre Parkway
Burke, VA 22015

☐ WIMC Fairfax Station
9015 Silverbrook Rd #106
Fairfax Station, VA 22039

Patient Pre-Registration Form

Date: ____________________

Patient Information

Last Name: ______________________________

First Name: ______________________________

Middle Initial ______

Address : ______________________________

City: ________________ **State:** ____ **Zip:** _______

Home: (_____) ____________________

Cell: (_____) ____________________

Work: (_____) ____________________

SSN: _______ - ____- ________

DOB: ___________ **Age:** _____

Gender: ☐ **M** ☐ **F**

Emergency Contact Relationship: ___________

Name: ______________________________

Phone Number: (_____) ________ - ___________

EMAIL: ______________________________

How you found out about us: ____________________

____

Parent/Guardian/Guarantor: Please provide YOUR information if patient is UNDER 18 years of age:

Last Name: ______________________________

First Name: ______________________________

Middle Initial: ____

Address: ______________________________

City: ______________ **State:** _____ **Zip:** __________

Home: (_____) __________________

SSN: ______ - _____ - __________ **DOB** ___________

Relationship to patient: ____________________

Insurance Information

Primary Insurance: ________________________

Policy Holder Information:

Last Name: ______________________________

First Name: ______________________________

Middle Initial: ____

Member ID: ______________________________

Group Number: ___________________________

SSN: ______ - _____ - _________

DOB: ____ / ____ / ________

Employer: ______________________________

Relationship to patient:

☐**SELF** ☐**SPOUSE** ☐**PARENT** ☐**CHILD**

Secondary Insurance: ________________________

Policy Holder Information:

Last Name: ______________________________

First Name: ______________________________

Middle Initial: ____

Member ID: ______________________________

Group Number: ___________________________

SSN: ______ - _____ - _________

DOB: ____ / ____ / ________

Employer: ______________________________

Relationship to patient:

☐**SELF** ☐**SPOUSE** ☐**PARENT** ☐**CHILD**

*** Please make sure to fill in how you heard about us and SIGN the SECOND PAGE.*

I hereby authorize Walk-In Medical Care, to release my Protected Health Information as described below: (check appropriate boxes)

Yes [ ] No [ ] Complete Medical Records

Yes [ ] No [ ] History and Physical (to include progress notes and consult notes)

Yes [ ] No [ ] Labs, X-rays, EKG etc.

Yes [ ] No [ ] STD-related information

Yes [ ] No [ ] Psychological reports

Yes [ ] No [ ] Developmental information

Yes [ ] No [ ] Other indicate

To: ____

____

This authorization is effective until I revoke it in writing.

As a courtesy to the patient, we will file the insurance claim with your insurance company, but you must understand that our relationship is with the patient and not the insurance carrier. The patient/guardian is the sole responsible party for all of the charges incurred at the time of visit and guarantees payment thereof. It is not our responsibility to understand the patients insurance plan benefits and/or member responsibilities. These include any deductibles which may be applied to the patients visit and/or obtaining authorizations/referrals required by the patient's insurance company prior to being seen in our clinic. The patient is expected to be fully aware of all aspects of their insurance policy. Failure to provide updated, correct insurance information and/or insurance required authorizations/referrals will result in all charges for services becoming the sole liability of the responsible party.

The treating physician may deem certain tests medically necessary in order to provide the patient with proper medical care. The patient will receive a separate bill from the laboratory for any samples sent to the lab such as blood work, pap smears, cultures, etc. If the patient accepts lab services without getting a required referral or authorization he/she understands that this means he/she will become responsible for this service. Again, it is the patient's responsibility to know what labs, including x-rays, his/her insurance policy does or does not cover and what needs prior authorization and/or a referral.

Consent, Insurance & Information Authorization

I hereby authorize Walk-in Medical Care to apply for benefits on my behalf for covered services rendered by them. I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information to my insurance carrier or me at any time in writing.

*I understand and agree to be responsible for any portion of this claim that for any reason is not covered by my insurance. ___________ (**responsible party's initials**)*

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including attorneys' fees, we incur in such collection efforts, as well as any service charges assessed to accounts with returned checks. I further consent that I authorize to be treated by the physicians and medical staff within the Walk-In Medical Care facility. I further certify that the information I provided above is true and correct.

****Patient/Guardian Signature*:* ___________________________ DATE:____________**

Patient/Guardian Printed Name:________________________________

*** Please make sure to fill in how you heard about us and sign the form.*