PATIENT REGISTRATION

PLEASE PROVIDE ALL INFORMATION REQUESTED. PLEASE PRINT CLEARLY

NAME:
_____
_
Last Name ***First Name (Full)*** ***Middle Initial***

ADDRESS:
_____
Street ***City*** ***State*** ***Zip***

TELEPHONE NUMBERS: (H) _____(W)
_____

(Cell)_____email_____
_____
*******(Please indicate (*) the preferred # for leaving messages)*******

DATE OF BIRTH: _____

OCCUPATION: _____

HOW DID YOU HEAR ABOUT US?
_____

PERSONAL PHYSICIAN: _____
NAME

_____
ADDRESS

_____
_____
TELEPHONE # ***FAX #***

Please provide name, address, telephone number and relationship of someone we may contact in case of emergency. Preferably a relative.	***Please provide name, address, telephone number and relationship of someone <u>not</u> living in your household who is likely to know how to contact you if we cannot contact you directly.***

Name		

Address		
Telephone # ***Cell #***		
Relationship		

Applicant's Signature: _____ Date: _____

PRIMARY INSURANCE	
Insurance Carrier with Phone Number	
ID Number	Group number
Subscriber's Name and relationship to patient	Subscriber's Date of Birth and Subscriber's Employer
SECONDARY INSURANCE (If applicable)	
Insurance Carrier with Phone Number	
ID Number	Group number
Subscriber's Name and relationship to patient	Subscriber's Date of Birth and Subscriber's Employer

PATIENT AUTHORIZATION & ASIGNMENT OF INSURANCE BENEFITS

I hereby authorize Washington Center for Weight Management & Research, Inc. (hereafter referred to as the Center) to apply for benefits on my behalf for covered services rendered by (please check all that apply):

Domenica Rubino, MD ____
Jessica Donze-Black, MPH, RD ____
Lauren Trocchio, RD, LD ____
Mougeh Yasai, PhD* ____
Sapna Doshi, PhD* ____
Gayle Alexander, LPC* ____

I request that payments be made directly to me. I understand that the Center is offering this service as a courtesy to their patients and is in no way responsible for the reimbursement rates set by any individual health plan, nor for the difference between fees paid to the Center and the dollars reimbursed to the patient by any individual health plan. Furthermore, the Center will not be responsible for the follow-up on any claims or related fees not accepted by any individual health plan.

I certify that the information I have reported regarding my insurance coverage is correct and current. I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time, in writing. This agreement shall be governed in accordance with the laws of the Commonwealth of Virginia.

_____ _____	_____
Signature of Patient, Parent, Insured, Spouse or Guarantor	Date

*Visits to these providers are listed as psychotherapy visits using a mental health diagnosis. Please discuss any concerns with the provider.