Linda C Wang, MD, LLC

1205 York Rd, Suite 39A ▪ Lutherville, MD 21093

Patient Information

_____ **Sex:** ❒ **M** ❒ **F**

Last Name **First Name** **Middle Initial**

_____ / _____ / _____ _____ - _____ - _____ **Marital Status:** ❒ **S** ❒ **M** ❒ **D** ❒ **W**

Date of Birth **Social Security Number**

_____

Address **Apt #** **City** **State** **Zip**

(_____) _____ (_____) _____ (_____) _____

Cell Number **Work Number** **Home Number**

May We Contact You Via? ❒ E-Mail ❒ Phone
May We Leave Messages? ❒ Yes ❒ No

_____

E-Mail Address

Race: ❒ Caucasian ❒ African American ❒ Asian ❒ American Indian ❒Hawaiian/Pacific Islander ❒ Decline
Ethnicity: ❒ Hispanic/Latino ❒Not Hispanic/Latino ❒ Decline

_____ (_____) _____

Emergency Contact Name & Relationship **Emergency Contact Phone Number**

Primary Insurance

_____

Insurance Company

_____

Name of Insured

_____ _____

Relationship to Policy Holder **Policy Holder Date of Birth**

_____

Policy Number/Subscriber Number/Member ID

_____ $_____

Group Number **Specialist Co-Pay**

_____

Insurance Billing Address (Back of Card)

_____

Insurance Billing Address Line 2

Secondary Insurance

_____

Insurance Company

_____

Name of Insured

_____ _____

Relationship to Policy Holder **Policy Holder Date of Birth**

_____

Policy Number/Subscriber Number/Member ID

_____ $_____

Group Number **Specialist Co-Pay**

_____

Insurance Billing Address (Back of Card)

_____

Insurance Billing Address Line 2

Billing Consent & Assignment

I am financially responsible for any and all co-pay, outstanding balance, cosmetic/non-covered charges, and in some cases, coinsurance and deductibles due at the time of service. I will be financially responsible for all charges due at the time of service if my physician is a non-participating provider with my health insurance or if I do not have health insurance. I will be financially responsible for a late cancellation/no show fee if I fail to cancel my appointment with at least 24 hours notice or if I no show for my appointment. I understand that without an authorization/referral from my insurance, I will be financially responsible for any and all charges I incur. I will be financially responsible to Linda C Wang, MD, LLC for professional services rendered by my physician. I may be financially responsible for services rendered by an outside laboratory and will direct any billing questions/disputes to the appropriate laboratory.

I authorize the submission and appeal of claim(s) to Medicare and other payers for any and all services provided to me by Linda C Wang, MD, LLC now, in the past, or in the future, until such time as I revoke this authorization in writing. I authorize the release of any and all medical information necessary to process any and all claim(s). I understand that such medical information may include treatment notes containing medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I permit a copy of this authorization to be used in place of the original. I authorize and assign all rights to payment of health insurance benefits directly to Linda C Wang, MD, LLC. I understand that I am financially responsible for charges not covered by my health insurance, including co-pay, deductible, coinsurance and non-covered charges. In the event of default and referral for collection, I agree to pay an attorney's fee of 15% of the outstanding balance, any and all court costs, and private process server fees incurred. I guarantee Linda C Wang, MD, LLC full and complete payment due by the patient when the same becomes due.

_____ _____

Signature of Patient/Responsible Party/Parent/Legal Guardian **Date**