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 & Secondary Insurance ❒ On File

I have provided a copy of my insurance card(s). I understand that I am responsible for all charges if my insurance coverage is inactive, terminated, or incorrect.

Notice of Privacy Practices

I acknowledge that a copy of Linda C Wang, MD, LLC Notice of Privacy Practices has been made available to me.

Billing Consent & Assignment

I am financially responsible for all co-pays, deductibles, co-insurance, and any remaining balance that my insurance plan (primary and secondary) does not cover for any reason. This includes any amounts that my insurance should have paid, but did not, after reasonable billing and appeal efforts. I understand that I am responsible for all charges at the time of service if I do not have active health insurance, if my physician does not participate with my insurance plan, or if I fail to obtain a required referral or authorization. If my physician is out-of-network with my insurance, I understand that I am financially responsible for higher deductibles and/or co-insurance. I will be financially responsible for all cosmetic or non-covered charges at the time of service. **I authorize Linda C Wang, MD, LLC to charge my credit card on file for any balance not paid by my insurance plan (primary or secondary) for any reason, including amounts that my insurance should have paid but did not, after my insurance plan has made final determination of benefits and reasonable billing and appeal efforts have been completed. Initial _____.** I understand that this is not balance billing, and charges will be limited to amounts permitted by Medicare or my insurance plan. **If I do not show or cancel my appointment with less than 24 hours' notice, I will be financially responsible for a $50 late cancellation/no show fee. Initial _____.** I understand that I will be financially responsible to outside laboratories that will bill me separately for services rendered and that I will direct any billing questions/disputes to the appropriate laboratory.

I authorize the submission and appeal of claim(s) to Medicare and other insurers 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 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. If my account becomes delinquent, I agree to be financially responsible for reasonable collection costs, including attorney's fees and court costs, as permitted by Maryland law. 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**