Center for Sleep and Wake Disorders
5454 Wisconsin Ave., Suite 1725, Chevy Chase, MD 20815
Patient Demographics

Patient Name: ______________________ **DRUG ALLERGIES:** ______________________
Address: ______________________ ______________________
______________________ Ht/Wt: __________
Work Phone: ______________ Home Phone: ______________
Cell: ______________ Email: ______________
Date of Birth: ____________ Sex: _____ Marital Status: __________
Employer: ______________ SS Number: ______________
Referring Doctor: ______________ Phone (if available): ______________

The current standard of care is that all eligible prescriptions be electronically sent to your pharmacy. This process is secure, has been demonstrated to significantly increase patient safety, and reduces the time that it takes for patients to fill their medications. Please fill in the following information about your preferred pharmacy (you may always change this information later):

Name: ____________ Address (if available): ______________ City/ZIP code: ____________

Guarantor Information
Name: ______________________ Relationship to Pt: ______________
Address: ______________________ Marital Status: __________
_, ______________________ DOB: __________
Home Phone: ______________ Work Phone: ______________
SS Number: ______________ E-Mail: ______________

Insurance Information (Primary; the address below may differ from the address on your insurance card)
Insurance Company: ______________________
Address: ______________________
_, ______________________
Phone: ______________ **Insured Party:** ______________
Insured DOB: ______________ **Relationship to Pt:** ______________
Group # ______________ **ID#** ______________

<u>OFFICE USE ONLY</u> EFF DATE:____/____/____ TERM DATE:____/____/____ DED:_____/_____ FDED:_____/_____ OOP: ______/______ FOOP: _____/_____

COINSURANCE:_______% SLP COPAY:$______ REF REQ?: YES / NO PRECERT REQ? NO / YES ____________________________ NO E/L

CLAIMS ADDRESS: ____ INFO SOURCE:___________ DATE:____/____/____

OA

RELAYED TO PT:____ HMO/ POS/ OON/ TCP/ EPO/ PPO/ IND O/V COPAY:$_____

Insurance Information (Secondary)
Insurance Company: ______________________
Address: ______________________
_, ______________________
Phone: ______________ **Insured Party:** ______________
Insured DOB: ______________ **Relationship to Pt:** ______________
Group # ______________ **ID#** ______________

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the informatio and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify you of changes in my health status or the above information.

Signature: ______________________________ **Date: ______________**

OFFICE POLICY

(Revised 12/01/2016)

We are committed to providing you with the best possible care. If you have medical insurance we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our office policy with regard to payment for services rendered.

At the present time we participate with Anthem Blue Cross/Blue Shield PPO, CareFirst BC/BS, Guardian, Medicare, NCPPO, PHCS, First Health, Kaiser Permanente, Maryland Medicaid, Medicare, Preferred Health Network, and TriCare. If we are contracted providers with your insurance, your signature on this form authorizes this office to submit all necessary forms for you. If we are not in network with your insurance you will be seen on a fee-for-service basis.

I request that payment of authorized benefits be made either to me on my behalf or to Dr. Emsellem for any services furnished to me by Dr. Emsellem's office. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the related services.

You are responsible for arriving for your visit with any necessary referral and for knowing whether or not your specific policy requires a referral. Any applicable copayments or coinsurance will be collected at the time of service, <u>as required by our contract with your insurance company.</u> If there is any outstanding balance after a claim is processed by your insurance company, you will be billed for the balance. Bills are due and payable upon receipt. If we do not participate as a provider for your insurance company, fees are due at the time services are rendered. We will provide you with the necessary information for you to submit to your insurance company for possible reimbursement. *Although we have your insurance ID#, we frequently require Social Security Numbers to verify benefits & to process the claim. If you do not wish to give us your SSN, and we are unable to bill a claim as a result, you agree to be fully responsible for the entire charge.*

- There is a $50 No Show charge for follow-up visits, a $375 No Show charge for new patient/consultation appointments and sleep studies. 24 hours notice is required for cancellation.
- There is a charge for copying records, the writing of letters on your behalf, and completion of forms other than standard insurance submissions.
- There is a $35 bad check fee.
- There is a $25-$45 letter writing/form completion fee.
- There is a $10 prescription prior authorization fee.

We will gladly answer any questions that we can relating to your insurance. You must realize that:

1. If you fail to provide us with valid insurance information or if you fail to provide your insurance company with any items they require to process claims within timely filing limits you will be responsible for all charges in full.
2. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If you belong to a health plan that requires you to have a referral from a primary care doctor in order to be covered for a visit it is your responsibility to have that referral in hand at the time of the appointment. If you arrive without the referral you are personally financially responsible for the cost of the visit. Many health plans will not allow primary care physicians to retroactively issue referrals. **If you do not arrive with your referral we will charge you the full amount of the visit and credit you back if you provide us with a referral within 48 hours of your visit. This is your responsibility.**

We must emphasize that as medical care providers our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered. We understand that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will always be willing to cooperate with you. If there are any questions regarding your insurance or our policies please do not hesitate to ask.

Signature	Date	name (printed)