

# THE VEIN CLINIC OF WASHINGTON

**SAMIR R. NEIMAT, M.D., P.A.**

5454 Wisconsin Avenue, Suite 1040

Chevy Chase, MD 20815

(301)270-VEIN(8346)

## PATIENT REGISTRATION

Last Name	First Name
M Initial	Sex
Address	City
State	Zip Code
Date of Birth	Social #
Home #	Work #
Cell #	Email
Emerg/Contact	Phone #
PCP	PCP #
Date/Last visit	Referred
Marital Status	Employer
Date of call	Appt. Date

## INSURANCE INFORMATION

Primary Ins.	Primary Hold Name
Insurance I.D.#	Group #
Policy Hold DOB	Relationship
Insurance #	Insurance address
City	State/Zip
Copay Primary	Copay Specialist
Referral needed	Preauth needed

Secondary Ins.	Primary Hold Name
Insurance I.D.#	Group #
Policy Hold DOB	Relationship
Insurance #	Insurance address
City	State/Zip
Copay Primary	Copay Specialist
Referral needed	Preauth needed

If you have any specific restrictions as to who or how we release information, please ask for a copy of our patient request to restrict the use or disclosure of PHI form.

All information released is in compliance with HIPAA as stated in our Notice of Privacy Practices.

### PATIENT AUTHORIZATION

I hereby authorize Samir R. Neimat, M.D., P.A. to apply for benefits on my behalf for services rendered by Samir R. Neimat, M.D., P.A. I request payment from my insurance company to be made directly to Samir R. Neimat, M.D., P.A. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

---

Signature of Subscriber or Beneficiary

Date