

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