Virginia Medical Alliance

vma

# PATIENT INFORMATION

Please Print

Last Name: _____ Social Security #: _____

First, M.I.: _____

Address: _____ Employer: _____

City: _____ State: _____ Zip: _____ Address: _____

Home Phone: (  ) _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: M / F Work Phone: _____

Marital Status: ----- Spouse;s Name: _____-

Ref By: _____ Primary VMA Dr.: _____

Responsible Party (If patient is a minor or employer is responsible) Emergency Contact:

Last Name: _____ Name: _____

First Name: _____ Phone: (  ) _____

Relation: _____ Relation: _____

## INSURANCE INFORMATION

### PRIMARY POLICY HOLDER

Company Name: _____

Company Address: _____

_____

ID / Certificate #: _____

Group #: _____

Plan #: _____

Policy Holder: _____

### SECONDARY POLICY HOLDER

Company Name: _____

Company Address: _____

_____

ID / Certificate #: _____

Group #: _____

Plan #: _____

Policy Holder: _____

I, the undersigned, hereby acknowledge that it is the policy of this office that payment bew made at each visit and I am responsible for payment of all services rendered on my behalf. In the event that failure to pay results in referral of my account for collection, I agree to pay collection or attorney fees. If the treating physician is a participant in a HMO, PPO or IPA of which I am a member, I agree to pay any co-payment required by my particular plan. Exception to this policy must be confirmed in advance of service.

Patient's Signature: _____ Date: _____

**MEDICARE PATIENTS ONLY:**

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to _____ M.D. for any services rendered to me. I authorized any holder of medical information about me to give the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ Date: _____

**OTHER INSURANCE PATIENTS:**

I authorize payment of medical benefits to the physician or supplier of services rendered.

Patient's Signature: _____ Date: _____

I authorized release of my medical information necessary to process this claim and also certify that the information obtained herein is correct.