Falls Church Healthcare Center
900 South Washington Street
Falls Church, VA 22046
(703) 532-2500 FAX: (703) 237-1184

First Appointment DATE _____ **by: online**
Type of Service_____

Additional **Appointment DATE** _____ **by:**
Type of Service_____

INSURANCE INFORMATION FORM

I. Patient Information

Patient Name: _____
Last First Middle

Date of Birth: _____ Social Security Number: _____

Address _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail (opt)_____

II. Primary Insurance Information

Name of Insurance Company: _____

Insurance Company Telephone: Member Service_____Provider:_____

Group #: _____ Insurance ID#: _____

Employer: _____ *Check if Government Policy* ☐ Employer Phone: _____

Policy Holder: **SELF** ☐ Other:_____
Last First Middle

Relationship to Policy Holder:_____ Policy Holder's DOB:_____ Policy Holder's SSN:_____

Policy Holder Address **SAME** ☐ _____
Street City State Zip Code

III. ☐check here if Secondary Insurance. Post information on additional form:

IV. For Office Use Only First appointment Verification of Benefits and authorizations BY_____

Diagnosis Code: _____ , _____ , _____ CPT Code: _____ , _____ , _____

Service Description:_____
Is this a covered benefit? Y N Is this a government policy? Y N Spoke with: _____ DATE_____

Does patient have deductible? Y N How much/met? $_____/$_____How much deductible still needed? $_____

Does patient have co-insurance? Y N What Percentage? _____% Co Insurance to Bill $_____Notified_____

Does patient have a Co-pay Amount? Y N How Much? $_____Policy Effective Dates:_____

Does patient need referral? Y N Is pre-authorization needed? Y N Phone # for Authorization Department? _____
Spoke with: _____DATE:_____Authorization #: _____ Good Through: _____
Patient Notified Of Benefits: date: by: NOTES:

V. For Office Use Only Additional appointment Verification of Benefits and authorizations BY_____

Diagnosis Code: _____ , _____ , _____ CPT Code: _____ , _____ , _____

Is this a covered benefit? Y N Is this a government policy? Y N Spoke with: _____ DATE_____
Does patient have deductible? Y N How much/met? $_____/$_____How much deductible still needed? $_____
Does patient have co-insurance? Y N What Percentage? _____% Co Insurance to Bill $_____Notified_____
Does patient have a Co-pay Amount? Y N How Much? $_____ Patient Notified Of Benefits:

VI. For Office Use Only Additional appointment Verification of Benefits and authorizations BY_____

Diagnosis Code: _____ , _____ , _____ CPT Code: _____ , _____ , _____

Is this a covered benefit? Y N Is this a government policy? Y N Spoke with: _____ DATE_____
Does patient have deductible? Y N How much/met? $_____/$_____How much deductible still needed? $_____
Does patient have co-insurance? Y N What Percentage? _____% Co Insurance to Bill $_____Notified_____
Does patient have a Co-pay Amount? Y N How Much? $_____ Patient Notified Of Benefits:

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Falls Church Virginia 22046

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FCHC@fallschurchhealthcare.com

INSURANCE RELEASE AND AUTHORIZATIONS

Authorization for Release of Information: I authorize Falls Church Healthcare Center to disclose all or any parts of my patient's medical record to listed insurance companies and any review agency which conducts practice utilization review under an agreement with patient's payment source. I also understand that I may revoke this authorization by providing written notice to Falls Church Healthcare Center (FCHC).

Patient's Certification: I certify that the information given by me in applying for payment by my insurance is correct and that my coverage will be in effect on the day I receive my medical services. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided according to HIPPA Regulations as stated in FCHC Privacy Policy.

Assignment of Benefits: I hereby authorize payment directly to the Falls Church Healthcare Center or its assigns by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payor.

Insurance: Your insurance plan is a contract between you and your insurance company. Falls Church Healthcare Center will file your insurance claim as a service to you. Although we rely on your insurance company's good faith pre-authorizations, verifications, certifications and coverage approvals and their reported co-pay, co-insurance and unmet deductible amounts the claim may be still be denied by your insurance company or some services will be excluded from coverage. We must hold you responsible for any balance due. Falls Church Healthcare Center will invoice you that amount; we request your prompt payment which may include unmet deductibles co-pays, co-insurance and denied coverage different from what was collected on the day of your medical services.

Requested Assistance; If our office does not hear from your insurance company within 30 days, we request your help in contacting your insurance company to resolve the payment delay or any unresolved issues.

Laboratory Billings: Your services may include laboratory studies required by your insurance company and or as a standard of care by your doctor. These services are NOT provided by FCHC but by an independent laboratory which submits their claim to your insurance company separately. Unmet deductibles, co-insurance and copay as well as denials by your insurance for those laboratory services will be your financial responsibility and invoiced by the laboratory providing the service.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services rendered to me at the center. I understand that laboratory services provided by other than FCHC may incur charges billed from the laboratory. I further understand that payment in full is expected upon receipt of Falls Church Healthcare Center's first invoice, which may include unpaid co-payments, additional co-insurance amounts, unmet deductibles and any fees for services excluded or denied by my insurance company such as medications, HPV testing and anesthesia. I understand I can request a payment plan to be arranged. I understand that 10% late fees may be attached to unpaid balances. I understand I am financially responsible for any legal fees and collection service fees related to the collection of my outstanding balance.

Please supply your insurance card and a photo I.D. at each visit

Please complete or verify the insurance information on the reverse of this page.

Patient Name (please print): _____ Date of Birth_____

Signature _____ Date _____

Witness _____ Date_____