OBSTETRICAL & GYNECOLOGICAL ASSOCIATES, P.C.

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Denita F. Speyer, M.D.
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21475 Ridgetop Circle Sut. 360
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Phone: 703.430.8844
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PATIENT REGISTRATION

PLEASE PRINT **PAYMENT DUE WHEN SERVICES ARE RENDERED**

DATE	REFERRED BY	RELIGION

PATIENTS LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	AGE	RACE	MARITAL STATUS
						M S D SEP. WID.

STREET ADDRESS	CITY	STATE	ZIP CODE	HOME/CELL NUMBER

OCCUPATION	SOCIAL SECURITY NUMBER	WORK NUMBER

EMPLOYERS NAME & ADDRESS

IN CASE OF EMERGENCY (OTHER THAN SPOUSE)	RELATIONSHIP	PHONE NUMBER

PRIMARY INSURANCE COMPANY	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS OF INSURANCE COMPANY	POLICY HOLDERS NAME

SPOUSE (PARENT IF A MINOR)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

NAME OF SPOUSE'S EMPLOYER	OCCUPATION	SPOUSE'S NUMBER

PRIMARY CARE PHYSICIAN	PHONE NUMBER	FAX NUMBER

SECONDARY INSURANCE COMPANY	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS OF SECONDARY INSURANCE COMPANY	POLICY HOLDERS NAME

PATIENT AUTHORIZATION & FINANCIAL POLICY

Payment: I agree and understand that I am personally liable to the medical service provider for payment of any balance on my account or on any account for which I am responsible as a parent or guardian (which may include professional service fees, missed appointment fees, bounced check charges, etc.) regardless of whether insurance benefits have been applied for or received, including interest on any outstanding balance(s) at the rate of 18% per annum accruing 30 days from the issuance date of the statement(s) and for all and any collection costs or fees, including but not limited to, 40% attorney's fees and court costs if the account(s) is/are turned over to a third party and/or an attorney for collection. I agree and understand that if I do not dispute in writing the amounts and charges set forth in any statement within 30 days after its issuance date that I am agreeing that the amounts and charges set forth in any statements are fair, reasonable and accurate. I agree and understand that if I file an action/counterclaim against the medical service provider/practice and the medical provider/practice incurs any costs and attorney's fees for its/their defense, I am liable for such costs and attorney's fees if the medical service provider/practice is the prevailing party in said proceeding, which shall include, but not be limited to, bankruptcy, arbitration, mediation, litigation or other process.

_____ _____

SIGNATURE DATE