

OBSTETRICAL & GYNECOLOGICAL ASSOCIATES, P.C.

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PATIENT REGISTRATION PAYMENT DUE WHEN SERVICES ARE RENDERED

PLEASE PRINT

DATE	REFERRED BY	RACE	RELIGION		
_____	_____	_____	_____		
PATIENTS LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	AGE	<u>M S D SEP. WID.</u> MARITAL STATUS
_____	_____	_____	_____	_____	_____
EMAIL ADDRESS					CELL NUMBER
_____					_____
STREET ADDRESS	CITY	STATE	ZIP CODE	HOME NUMBER	
_____	_____	_____	_____	_____	
OCCUPATION	SOCIAL SECURITY NUMBER			WORK NUMBER	
_____	_____			_____	
EMPLOYERS NAME & ADDRESS					

SPOUSE (PARENT IF A MINOR)	DATE OF BIRTH	SOCIAL SECURITY NUMBER			
_____	_____	_____			
NAME OF SPOUSE'S EMPLOYER	OCCUPATION	SPOUSE'S PHONE NUMBER			
_____	_____	_____			
IN CASE OF EMERGENCY (OTHER THAN SPOUSE)	RELATIONSHIP	PHONE NUMBER			
_____	_____	_____			
PRIMARY INSURANCE COMPANY					

PATIENT AUTHORIZATION AND FINANCIAL POLICY

Payment: I agree and understand that I am personally liable to the medical services 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 checks 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 part in said proceeding, which shall include, but not be limited to, bankruptcy, arbitration, mediation, litigation or other process.

SIGNATURE

DATE
