MARC L. CHAIKEN, M.D., P.A. **COLUMBIA SURGERY CENTER INC**.
11055 LITTLE PATUXENT PARKWAY COLUMBIA, MD 21044

Date _____ Home Phone No _____

Name _____ Cell Phone No_____

Street _____ Social Security No. _____

City, State, Zip _____ Date of Birth _____ Age_____

Sex _____ Marital Status: Single___ Married ___ Widowed ___ Other _____

Are you a student? Yes___ No___ Occupation_____

Patient's Employer _____Work Telephone No _____

Name of Insured _____ Insured's Date of Birth_____

Insured's Employer _____ Insured's Soc. Sec No. _____
Insured's Work No: _____

Referred by: __Doctor, Name & Address_____
__Relative, Name _____
__Friend, Name _____
__Yellow Pages
__Insurance Book

Name of the nearest relative not living with you: _____ Phone No_____

Family physician or primary care physician name, address and phone number:
_____

INSURANCE
Primary Insurance Co. _____
Address _____ Telephone No. _____
Identification No._____ Group No. _____
Policyholder _____ Relationship to patient _____

Secondary Insurance Co. _____
Address _____ Telephone No. _____
Identification No. _____ Group No. _____
Policyholder _____ Relationship to patient _____

I authorize the release of any medical information necessary to process this claim. I further authorize payment of medical benefits directly to the physician or supplier for services rendered.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to MLCMDPA and the CSC Inc. for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Lifetime Signature _____ Date _____

MARC L. CHAIKEN, M.D., P.A. **COLUMBIA SURGERY CENTER INC**.
11055 LITTLE PATUXENT PARKWAY COLUMBIA, MD 21044
(Please turn over to complete)

POLICY OF PAYMENT FOR MEDICAL SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is required at the time of service. We accept cash, checks, VISA or MasterCard. In the event that the courtesy of filing your insurance claim is extended to you, you must realize that all charges are your responsibility from the date the services are rendered. Due to the ever changing health insurance laws and regulations, we cannot guarantee that all services rendered are covered by your insurance policy. In the event that your insurance does not cover our services, you will be responsible for payment. You are reminded that you (not your insurance company, federal or state agency or any other third party) are ultimately responsible for the payment for our services.

Failure to pay bills promptly will result in legal action being undertaken to achieve collections. All collection expenses, attorney fees and court costs will be the responsibility of the patient or their responsible party. There may be additional rebilling fees of up to $10 per rebilling effort and interest charges of up to 1.5% per month on any balance that remains unpaid beyond 30 days. There may also be a fee charged to me (of up to $35) for any checks returned to us as unpaid and for missed appointments that I fail to cancel in advance in a timely manner.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Please sign below to indicate that you have read and understand our Policy of Payment for Medical Services.

_____
Patient or Responsible Party

It may be appropriate to send some office communications, newsletters and or laboratory data or test results to our patients on some occasions. If you give us permission to do so, we will send them to you via an email address. If you would like us to attempt to communicate to you via an email address that you feel is secure please indicate by designating that email address and signing below to allow us to “correspond” in this manner.

Email Address: _____

Signature Giving Permission to send you Email: _____ Date: _____