

CONTEMPORARY FAMILY MEDICINE ASSOCIATES, P.A.
BOARD CERTIFIED FAMILY PHYSICIANS ~ FULL SERVICE MEDICAL SPA

5530 WISCONSIN AVENUE, SUITE 1149 • CHEVY CHASE, MD 20815

NAME: _____ **DOB:** _____

ADDRESS: _____ **APT #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP TO PATIENT:** _____

PHONE NUMBER: _____

PRIMARY INSURANCE INFORMATION

**This information will be used to file claims on your behalf. CFMA is not a participating provider with any insurance carrier except Medicare.*

INSURANCE COMPANY: _____

ID #: _____ **GROUP #:** _____

PRIMARY INSURANCE HOLDER'S NAME: _____

ADDRESS: _____

HOME PHONE: _____ **WORK/CELL PHONE:** _____

DATE OF BIRTH: _____ **SSN:** _____ **EMPLOYER:** _____

PLEASE PROVIDE SECONDARY INSURANCE INFORMATION IF APPLICABLE

INSURANCE COMPANY: _____

ID #: _____ **GROUP #:** _____

PRIMARY INSURANCE HOLDER'S NAME: _____

ADDRESS: _____

HOME PHONE: _____ **WORK/CELL PHONE:** _____

DATE OF BIRTH: _____ **SSN:** _____ **EMPLOYER:** _____

RELEASE OF MEDICAL INFORMATION

I authorize Contemporary Family Medicine Associates, (CFMA), to release medical records to any physician, hospital, or agency involved in the care of the patient listed.

CANCELLATION POLICY

Our office requests that if an appointment needs to be canceled or rescheduled, that we receive notice no later than 24 hours prior to the appointment time. We reserve the right to charge a “no-show” fee of \$30.00 for office visits and \$75.00 for physical exams.

EMAIL PRIVILEGES

With your approval, CFMA will send lab results and other medical information to your designated email address. We cannot guarantee the security of files transferred via email. Email communication is to be used for results, follow-up questions regarding results, or new consults. Personal email addresses are preferred.

I consent to my email address being used for patient contact: _____ YES _____ NO

Email address: _____

Please note that email addresses are only used by CFMA, its billing company, and the patient. CFMA does not provide patient email addresses to any company, agency, or individual.

TELEPHONE AND EMAIL CONSULTS

The physicians of CFMA prefer that all consults and medical questions that require diagnosis and treatment be performed in the office. If a patient is unable to come in, we do offer email and telephone consults at a fee of \$50.00, if it is deemed medically appropriate to have such a consult.

HIPAA

CFMA has made available a copy of their privacy statement and how it pertains to me. I have had the opportunity to ask questions about the HIPAA statement prior to signing this form.

PAYMENT POLICY

I understand that CFMA is not a participating provider with any insurance company except Medicare. I am responsible for all charges incurred. As a courtesy, CFMA will file medical claims to my insurance company on my behalf. I understand that I am responsible for any and all balances regardless of the EOB (explanation of benefits) provided by my insurance company. CFMA will provide me with any receipts or copy of charges at the time of service if requested. Please see attached **FINANCIAL AGREEMENT**.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION AND OFFICE POLICIES.

X _____ X _____
Signature of responsible party Date read and signed