For the following insurances, please fill this form:

Amerigoup (Maryland not PAC)

Carefirst Bluecross Blueshield (BCBS)

Medicare

Medicaid

Maryland Physicians Care

Riverside

Also, fill this form for cases of:

Motor Vehicle Accident (MVA)

Workers' Compensation

REGISTRATION FORM

PLEASE COMPLETE THE FOLLOWING INFORMATION (PLEASE PRINT CLEARLY AND LEGIBLY)

DATE: / / 20 REASON FOR VISIT: _____

NAME OF YOUR PRIMARY CARE PHYSICIAN: _____

PATIENT INFORMATION

LAST NAME: _____FIRST:_____MI_____

ADDRESS: _____ APT #:_____

CITY: _____ STATE: _____ ZIP: _____

HOME #:(_____)_____ CELL #:(_____)_____ WORK #:(_____)_____

Email: _____

SOCIAL SECURITY #:_____-____-_____ SEX: □M □F DATE OF BIRTH: ____/____/____ AGE:____

RACE: _____ ETHNICITY: _____ MARITAL STATUS: _____

EMPLOYER: _____

EMPLOYMENT STATUS: □ FULL TIME □ PART TIME □ RETIRED

EMERGENCY CONTACT

NAME: _____ LEGAL GUARDIAN: □Y □N Relationship:_____

HOME #: (_____)_____ CELL #: (_____)_____ WORK #: (_____)_____

GUARANTOR

GUARANTOR: _____RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

HOME #: (_____)_____ CELL #: (_____)_____ WORK #: (_____)_____

SEX: □M □F DATE OF BIRTH: ____/____/_____ AGE: ____

EMPLOYER: _____

INSURANCE INFORTMATION

INSURANCE: _____ SUBSCRIBER ID: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER DOB: _____/_____/_____

RELATIONSHIP TO PATIENT: _____

Secondary Insurance (if applicable)

INSURANCE: _____ SUBSCRIBER ID: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER DOB: _____/_____/_____

RELATIONSHIP TO PATIENT: _____

AUTHORIZATION FOR CLAIMS PAYMENT AND REVIEWS

1. **Assignment and Coordination of Insurance Benefits:** I authorize Express Healthcare, LLC, to apply benefits on my behalf for services rendered by Express Healthcare, LLC. I also agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Express Healthcare, LLC (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Express Healthcare, LLC (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services:** I understand if my Insurance Plan(s) does not consider any service rendered during the visit covered service or has not authorized this service, they will not pay for this visit or the service rendered during this visit or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, deductible, co-insurance or other charge. In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only**: I request that payment of authorized Medicare benefits be made on behalf to Express Healthcare, LLC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

   By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. I also agree in the event my account must be placed with a collection agency to obtain payment, I will pay the reasonable collection costs of 45% incurred by Express Healthcare, LLC. *I understand and agree this document will remain in effect for all future outpatient or physician visits to Express Healthcare, LLC*, unless specifically rescinded in writing by me.

Patient Signature: _____ Date: _____

Patient Name: _____

If Representative, Print Name and Relationship to Patient:

_____

How did you hear about Express Healthcare, LLC?

Internet

☐ Web Search (Google, Bing, Yahoo, etc.)

Keywords used in search: _____

☐ Location-Based Services (Foursquare, Yelp, Google Maps, etc.)

☐ Online Ads (Diamondback, UMD apps, YP.com, etc.)

☐ Social Media (Twitter, Pinterest, Facebook, YouTube, etc.)

☐ www.ZocDoc.com

Word Of Mouth

☐ Relative/Family Member

☐ Friend

☐ Referral by Dr. _____

Others:

☐ Outdoor Signage

☐ _____ Insurance Company

☐ _____ Hospital

☐ Other than all above, please write below:

_____