PATIENT REGISTRATION

NOTICE: AUTOMOBILE ACCIDENT PATIENTS
(Addendum to Assignment of Benefits Form)

If you have been in an automobile accident you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form, you are giving to your health care provider the right to receive some or all of the payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: As long as you provide information necessary to verify your health insurance coverage, the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductible to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance or your healthcare provider is not in your health insures providers network, your healthcare provider may bill its full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. **You are not required to sign/initial this form to receive care. However, if you do not sign this form you will be required to (i) pay any applicable co-pays and deductibles at the time the services are provided and allow us to bill your health insurance company or (ii) pay for all care at the time of service.**

By signing below, I acknowledge that I have read or had the opportunity to read this notice.

Patient Signature: _____

Date: _____

PATIENT REGISTRATION

WAIVE HEALTH INSURANCE BILLING IN AUTOMOBILE ACCIDENT CASE

I _____, have instructed V. Sharma M.D. to file the bill for this automobile accident with the attorney/automobile insurance.

I understand that automobile accident cases require a significant amount of additional work, time and expense.

In case the attorney/automobile insurance does not make any payments, I will be held responsible for the bill.

Patient Name: _____

Signature: _____

Date: _____

V SHARMA MD
2841 HARTLAND RD SUITE 402 FALLS CHURCH VA 22043 PH (703) 778-1800 FX (703) 778-1803

PATIENT REGISTRATION

Irrevocable Assignment of Benefits, Authorization and Lien

Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and **between** _____ ("Patient") and "V.Sharma, M.D.". With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers sets over and assigns to Health Care Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below, up to the total amount due and owing the Health Care Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Health Care Provider, including, without limitation, requested reports, collection costs and expenses and attorney's fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this Assignment is provided to withhold from Patient and pay directly to such Health Care Provider such amount(s) from (1) any insurance benefits payable to patient or on Patients behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, personal injury protection benefits, third-party liability coverage, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patients favor as may be necessary to fully pay any and all financial obligations owed to the Health Care Provider by the patient. This Assignment is to be a complete and current transfer of Patients right, title, and interest, separate from any statutory or contractual lien or claim to which the Health care provider may also be entitled. Patient acknowledges that Health Care Provider has a substantial pecuniary interest in the enforcement of this Assignment.

The Patient further agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Health Care Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Health Care Providers total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Health Care Provider any and all causes of action that Patient might have or that might exist in Patients favor against such insurance company and/or attorney with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes, nominates and appoints as Patients attorney-in-fact any officer of Health Care Provider, to prosecute said causes(s) of action either in Patients name or in the Health Care Providers name and Patient further authorizes the Health Care Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Health Care Provider, Patient hereby grants a lien to said Health Care Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Health Care Provider. The Patient further agrees that the statute of limitations applicable to Health care provider's right to demand payment from the patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patients the individual or entity whose negligence is alleg**ed to have caused Patients injuries.**

PATIENT REGISTRATION

Irrevocable Assignment of Benefits, Authorization and Lien

Notwithstanding the foregoing, the Patient agrees that until the Health Care Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Health Care Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understands and agrees that this Assignment does not constitute any agreement of or consideration for the Health Care Provider to await payments from any source, and in the event the Health Care Provider deems itself in its sole discretion insecure as to the prospect payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Health Care Provider to release this Assignment and any information pertinent to Patients case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Health Care Provider as Patient's **attorney**-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to Patient by said Health Care Provider.

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice regarding the assignment of medical expense benefits is provided in a separate document. I have been presented with and had an opportunity to read the notice,
Acknowledged: _____ **(patient initials)**

Witness the following signatures and seal as of the indicated date:

Patients Signature:_____ **SS#** _____ **Date**:_____
_____

Health Care Provider

V.Sharma, MD.

Witness signature:_____ **Date**: _____

Attorney's name (printed): _____ **Date**:_____
_____

Attorney's signature: _____

PATIENT REGISTRATION

Name _____ Date of birth _____

Address _____ SS# _____

Home Phone _____ Cell Phone _____ Email _____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Home Phone _____ Cell phone _____

ATTORNEY/WORKERS COMPENSATION INFORMATION

MARK ONE: ☐ Car accident ☐ Workers Compensation Date of Injury ____/_____/____

Attorney's Name:

_____

Address:

_____

Phone Number:

_____

Workers Compensation Insurance Name:

_____

Car Accident - Third Party Insurance Name:

_____

Policy/Claim Number:

_____

PIP Insurance Name: (Your auto insurance)

_____

Policy/Claim Number:

_____

PREFERRED PHARMACY

Pharmacy name _____ Phone _____

Pharmacy Store Number _____ Fax _____

Address _____

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE INFORMATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician for the services rendered by her in person or under her supervision. I understand that I am financially responsible to any balance not covered by my insurance. I also authorize Dr. Sharma or insurance company to release any medical information required to either process my claims or for medical care.

Patient/ Guardian Signature _____ Date _____

V SHARMA MD
2841 HARTLAND RD SUITE 402 FALLS CHURCH VA 22043 PH (703) 778-1800 FX (703) 778-1803

PATIENT REGISTRATION

MEDICATIONS (Use back of sheet if you need to)	ALLERGIES
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Describe injury events (How did it occur? Were you taken to the hospital?)

Do you experience headaches?

☐ Yes
☐ No

Intensity 1-10 (10 being the worst) _____

Duration (How long does it last?) _____

Quality

☐ Pressure
☐ Throbbing

Location

☐ Top
☐ Back
☐ Forehead
☐ All Around

Do you experience neck pain?

☐ Yes
☐ No

Intensity 1-10 (10 being the worst) _____

Duration (How long does it last?) _____

Any pain down the arms? Which arms? _____

Do you experience back pain?

☐ Yes
☐ No

Intensity 1-10 (10 being the worst _____

Duration (How long does it last?) _____

Any pain down the legs? Which legs? _____

Do you experience any numbness?

☐ Yes
☐ No

If yes, what part of body? _____

Do you exercise?

☐ Yes
☐ No

If yes, how often? _____

Do you smoke?

☐ Yes
☐ No

If yes, how often? _____

Do you consume alcohol?

☐ Yes
☐ No

If yes how often? _____

Do you experience blurred vision?

☐ Yes
☐ No

Do you experience concentration or memory difficulties?

☐ Yes
☐ No

Do you experience hearing difficulties?

☐ Yes
☐ No

Do you experience anxiety?

☐ Yes
☐ No

Do you experience sleeping difficulties?

☐ Yes
☐ No

Do you experience dizziness?

☐ Yes
☐ No

(Women) Are you pregnant?

☐ Yes
☐ No

V SHARMA MD
2841 HARTLAND RD SUITE 402 FALLS CHURCH VA 22043 PH (703) 778-1800 FX (703) 778-1803

PATIENT REGISTRATION

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that the Notice describes certain rights I have under federal and state law and discusses how my medical information may be used by Dr. Sharma. If I have questions or complaints regarding my privacy rights I will be given an opportunity to ask.

Patient/ Guardian Signature _____ Date _____

FOR OFFICE USE ONLY

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Other (Please specify:

FINANCIAL POLICY STATEMENT

It is the patient's responsibility to know their insurance policy and its limitations. Although we check your insurance benefits as a courtesy to you, it is crucial that you are personally aware of your insurance benefits. We will not become involved in disputes between you and your medical insurance company regarding eligibility, deductibles, co-payments, co-insurance payments, covered charges etc., other than to supply factual information as necessary. If there are any changes to your insurance you are responsible to advise us of those changes and present the new card for your records. These fees include but are not limited to, collection agency fees and attorney fees.

MEDICARE

Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurance that automatically crossover through the CMS (Medicare system). If your secondary insurance does not crossover, it is the patient's responsibility to contact Medicare or file these claims themselves. Any outstanding balances and deductibles are due prior to your appointments. Any coinsurance and non-covered service will be due as service is rendered.

METHODS OF PAYMENT

Our office accepts the following payments methods: cash, personal checks, VISA & MasterCard credit cards. We will assess a $35.00 NSF charge on all returned checks.

CANCELATIONS/NO SHOW POLICY

The appointments made represent time set aside specifically for you. **All cancellations should be made at least 24 hours prior to the scheduled visit.** By law, all cancellations and no-shows involving workers compensation claims must be reported to your physician and your claims adjuster. **All no-show appointments will be charged a $25.00 fee for follow ups, $30.00 for Quotient and $50.00 fee for tests PSG, CPAP, MSLT, EEG and EMG.**

Patient/ Guardian Signature _____ Date _____

V SHARMA MD
2841 HARTLAND RD SUITE 402 FALLS CHURCH VA 22043 PH (703) 778-1800 FX (703) 778-1803

Submit Print Form