

# J. Richard Lilly, M.D., A.B.F.P., & Associates, P.C.

## PATIENT REGISTRATION - Please PRINT Clearly

Patient Name First Middle Last			Date of Birth		Age			
Home Address			Apt. No.	City		State	Zip code	
Occupation		Social Security No.		Marital Status	Sex M F	Home Phone		Cell Phone
Employer		Address					Work Phone	
Spouse (or Parent) Name			Spouse (or Parent) Home Phone			Spouse (or Parent) Work Phone		
Spouse (or Parent) Address								
Emergency Contact			Relationship		Home Phone		Work Phone	
Referred By:				E-MAIL:				

## BILLING AND INSURANCE INFORMATION

Insurance Company Name (PRIMARY)			Co-Pay \$	ID or Policy Number		Group / Code	
Insurance Company Address			Subscriber's Social Security			Date Effective	
Subscriber's Name		Sex M F	Home Phone			Work Phone	
Subscriber's Address				Subscriber's Date of Birth		Relationship to Patient	
Insurance Company Name (SECONDARY)			Co-Pay \$	ID or Policy Number		Group / Code	
Insurance Company Address			Subscriber's Social Security			Date Effective	
Subscriber's Name		Sex M F	Home Phone			Work Phone	
Subscriber's Address				Subscriber's Date of Birth		Relationship to Patient	

## POLICY CONCERNING PAYMENT OF MEDICAL BILLS / PATIENT AUTHORIZATION

I hereby authorize payment directly to J. Richard Lilly, M.D., A.B.F.P., & Associates, P.C., for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.  
I have reviewed the practice's notice of privacy practice for information regarding the practice's use of protected healthcare information. I authorize the above doctor and / or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature or copy on all insurance submissions.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Account #:

Entered By:

Appt with Dr.:

# Patient Registration Form

<b>Patient Information</b>		
Account # _____	DOB _____	Home # _____
Last Name _____	_____	Work # _____
First Name _____	SSN _____	Cell# _____
Middle _____	Suffix _____	Email _____
Address 1 _____	City _____	Employer _____
_____	State _____	Gender _____
Address 2 _____	Zip Code _____	Marital Status _____
Emergency Contact: _____	Phone _____	Relationship to Patient: _____

<b>Meaningful Use Information:</b>		
Race: _____	Ethnicity: _____	Language: _____

<b>Guarantor Information (Responsible for Bill)</b>			Gender: _____	DOB: _____	SSN: _____
Guarantor Name: _____	_____	_____	Home Phone _____	Work Phone _____	Cell Phone _____
First	Middle	Last			
Mailing Address _____			City _____	State _____	Zip _____

<b>Insurance Information - Primary</b>			<b>Insurance Information - Secondary</b>		
Subscriber Name: _____	_____	_____	Subscriber Name: _____	_____	_____
Subscriber DOB: _____	_____	_____	Subscriber DOB: _____	_____	_____
Insurance Carrier: _____	_____	_____	Insurance Carrier: _____	_____	_____
Certification/ID # _____	_____	_____	Certification/ID # _____	_____	_____
Group #: _____	_____	_____	Group #: _____	_____	_____

<b>Claims Mailing - Primary</b>			<b>Claims Mailing - Secondary</b>		
_____	State: _____	_____	_____	State: _____	_____
Address _____	Zip: _____	_____	Address _____	Zip: _____	_____
City: _____	Phone: _____	_____	City: _____	Phone: _____	_____

<b>Worker's Comp/Auto Liability Information</b>			Case Number: _____
Carrier Name: _____	_____	_____	Contact Name: _____
Fax Number: _____	_____	_____	Contact Phone#: _____
Mailing Address _____			City _____ State _____ Zip _____

<b>POLICY CONCERNING PAYMENT OF MEDICAL BILLS / PATIENT AUTHORIZATION</b>	
<p>I hereby authorize payment to J. Richard Lilly, M.D., A.B.F.P., &amp; Associates, P.C., for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. This authorization shall remain valid, until written notice is given by me revoking this authorization.</p> <p>I have reviewed the practice's notice of privacy practice for information regarding the practice's use of protected healthcare information. I authorize the above doctor and / or any provider or supplier of services in this office to release any information that is needed during my care and information required to secure the payment of benefits. I authorize the use of this signature or copy on all insurance submissions. This shall remain valid until written notice is given by me to the office revoking this authorization.</p>	
Signature: X _____	Date: _____

## **WORKERS' COMPENSATION INSURANCE INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### **EMPLOYER'S WORKERS' COMPENSATION INSURANCE CARRIER**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Adjustor Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_

Policy Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

### **ATTORNEY INFORMATION (IF APPLICABLE)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

### **YOUR PRIVATE HEALTH INSURANCE INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Relationship to Policy Holder: (Please Circle)      Self      Spouse      Parent      Other

Identification Number: \_\_\_\_\_ Copay Amount: \_\_\_\_\_

# Workers Compensation Information

Patient's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_

Did you report the accident to your supervisor? Yes No

Date of Accident or onset of disease: \_\_\_\_\_ Time: \_\_\_\_\_

Is this a re-injury of a previous accident? Yes No

If yes, give date of original injury: \_\_\_\_\_

Date disability began: \_\_\_\_\_ Description of accident: \_\_\_\_\_

\_\_\_\_\_

Were you treated by anyone else for this injury? Yes No

If yes, name of doctor and/or hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Were x-rays taken? Yes No if yes, results: \_\_\_\_\_

Treatment given and/or recommended: \_\_\_\_\_

## FOR OUR FEMALE PATIENTS

Are you pregnant? Yes No

Is there a possibility that you are pregnant? Yes No

If you should become pregnant during your course of treatment you must advise your physician.

Please initial that you have read the above information. \_\_\_\_\_ (Initial)

Prince George's County Medical Society / Bar Association

**Assignment and Authorization**

Health Care Provider

**J. Richard Lilly, M.D., A.B.F.P., Chartered**

5804 Baltimore Avenue  
Hyattsville, MD 20781  
(Primary Office)

Date: \_\_\_\_\_

You are hereby authorized to disclose and / or furnish my Attorney / Insurance Co. \_\_\_\_\_ any and all medical information, records, and bills in your possession, (including any and all medical information, records and bills originating from any other health care provider), which they request in reference to any illnesses and injuries suffered by including but not limited to the injuries which were sustained on \_\_\_\_\_. The authorization to obtain medical records and information contained in this paragraph expires one year from this date, unless extended or renewed in writing by me.

I further irrevocably assign to you, and authorize and direct said attorney to pay from the proceeds of any recovery in my case, all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner.

It is further understood that the statute of limitations in this state is three (3) years from the time said services were last performed and I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date which is beyond the three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitation with respect to any claim for services mentioned above will not begin to run until there is a denial in writing by us of any balance claimed to be due and owing to you by me.

Print Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Witness: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

The undersigned Attorney for the patient referred to above hereby agrees to comply fully with the foregoing "Authorization and Assignment" and agrees to advise the named health care provider in writing the status of the claim of the patient within ten (10) days of the request. I agree to notify the physician if I discontinue representation of the client.

Attorney Name: \_\_\_\_\_  
Firm Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
  
Attorney Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

## **PAYMENT RESPONSIBILITY**

I understand that I have a personal and primary obligation to pay for all medical services when rendered and I agree to pay all bills promptly. I further understand that although J. Richard Lilly, M.D. & Associates may submit a bill to my insurance company for payment as a service to me, that service does not relieve me of my personal responsibility to ensure that the insurance company makes payment according to the terms of my policy. I am aware that insurance payment / reimbursement may not cover the total balance due for the medical services I received. I agree to pay any outstanding balance on my account. I also agree to pay any and all legal expenses and fees incurred for the purpose of collecting payment for an outstanding balance on my account, if such action is deemed necessary. In addition, I agree to pay interest (at 1 ½ % per month) on my outstanding account balance if this balance extends beyond thirty (30) days of receipt of my bill. I agree to pay any additional fees and / or costs incurred in order to collect payments on my account if the balance is outstanding beyond one hundred and twenty (120) days including all legal and court costs on my account(s). I waive my rights under Maryland's statute of limitation should reconciliation of my account extend beyond three (3) years from the date of service.

Patient / Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

## **INSURANCE AUTHORIZATION**

### **AUTHORIZATION OF ASSIGNMENT**

I hereby authorize J. Richard Lilly, M.D., & Associates to apply for benefits from my insurance company on my behalf for covered services by J. Richard Lilly, M.D., & Associates. Finally, I authorize the release of any medical or other information necessary to process claims submitted to my insurance company.

Patient / Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

### **AUTHORIZATION OF PAYMENT**

I hereby authorize payment to be made directly to J. Richard Lilly, M.D., & Associates.

Patient / Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

### **MEDICARE INSURANCE ONLY**

I hereby authorize any holder of medical information about me to release to the health care financing administration and its agents, any information to determine the benefits payable for related services. I also authorize J. Richard Lilly, M.D. & Associates to investigate the non-paid status of my account with Medicare.

Patient / Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Please be advised that we have found that most insurance carriers have limited or no benefits for durable medical equipment (slings, braces, etc.), therefore we must collect from you the fee for the equipment at the time of service. Custom made braces are partially covered by some insurance carriers. At the time of measuring you for the custom made brace, we will contact your insurance carrier to verify coverage and give you an estimate of our responsibility. Thank you for your cooperation. \_\_\_\_\_

(Initials)

## FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money; therefore, all patients will be required to establish financial arrangements for payment of their account either through an attorney, responsible insurance company, or payment directly from the patient at the time of service.
- All patient accounts are due and payable within 30 days of services rendered. As a courtesy our practice will establish a reasonable monthly payment plan to accommodate your needs or bill the insurance company you provide information on, as the responsible party for your injury. If payment from this company is not paid within 30 days, you, the patient, will be responsible and billed for such services. It is in your best interest to assist this office in getting payment directly from the insurance company or providers, so that out-of-pocket expenses are limited. If an attorney represents you, please give this office that information and an assignment agreement will be made with the attorney to have bills paid at the time of settlement.
- It should be mentioned that your insurance coverage is an agreement between you and your auto insurer, your employers WCC carrier, or the insurance carrier of the place where you were injured. It is your responsibility to remit payment for charges not covered by your claim. You will be required to pay for services at the time of visit or establish written financial agreements with our practice until your insurance problem is resolved.
- Each month you will receive a monthly statement for services which is due and payable within 30 days. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.
- All patients refusing to remit payment after 60 days of notice without pending insurance or a financial agreement will force us to limit their future credit until the previous balance is paid in full or written financial arrangements are accomplished. All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency.
- Please notify us immediately if a mistake appears on the statement.
- Our practice firmly believes that a good doctor / patient relationship is based upon understanding and open communications. I have instructed our staff to make every effort available to you to clarify any misunderstanding you may have concerning your balance. We hope to possibly avoid any disagreement over payment for professional services. If you have any questions concerning our policy or need assistance, please contact us immediately.

Thank you,  
Administrative Staff

---

Patient Signature:

Date: