# 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

## Patient Information

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: ______

## Meaningful Use Information:

Race: Ethnicity: Language:

## Guarantor Information (Responsible for Bill)

Gender: ______ DOB: ______ SSN: ______

Guarantor Name: ______ First Middle Last ______ Home Phone ______ Work Phone ______ Cell Phone

______ Mailing Address ______ City ______ State ______ Zip

## Insurance Information - Primary

Subscriber Name: ______
Subscriber DOB: ______
Insurance Carrier: ______
Certification/ID # ______
Group #:

## Insurance Information - Secondary

Subscriber Name: ______
Subscriber DOB: ______
Insurance Carrier: ______
Certification/ID # ______
Group #:

## Claims Mailing - Primary

______ State: ______
Address ______ Zip: ______
City: Phone:

## Claims Mailing - Secondary

______ State: ______
Address ______ Zip: ______
City: Phone:

## Worker's Comp/Auto Liability Information

Case Number: ______
Carrier Name: ______ Contact Name: ______
Fax Number: ______ Contact Phone#: ______

______ Mailing Address ______ City ______ State ______ Zip

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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.

**Signature: X ______________________ Date: ______________________**

# AUTO ACCIDENT INSURANCE INFORMATION

Patient's Name: ________________________________________________ D.O.B. ___________________

Were you in your vehicle at the time of the accident? Yes No
Were you the driver or passenger in the vehicle? ________________________________________________

## OWNER OF THE VEHICLE THAT YOU WERE IN

Owners Name: __________________________________________________________________________

Address: ____________________________________________________ Phone: (_____) ______________

## AUTO INSURANCE OF THE VEHICLE YOU WERE IN

Auto insurance name: ____________________________________________________________________

Auto insurance address: __________________________________________________________________

Policy #: ______________________________________ Claim #: __________________________________

Adjuster's Name: ____________________________________________ Phone: (______) _______________

Does the owner of this vehicle have Personal Injury Protection? Yes No

Was there another vehicle involved in the accident? Yes No
**If yes complete the following:**
Driver of that vehicle's Name: _______________________________________________________________

Driver's Address: __________________________________________________________________________

Owner of vehicle's Name: ___________________________________________________________________

Owner of vehicle's Address: _________________________________________________________________

## OWNER OF THE OTHER VEHICLE AUTO INSURANCE

Auto insurance Name: ______________________________________________________________________

Address: _________________________________________________________________________________

Phone #: _______________________________________ Policy #: _________________________________

## ATTORNEY INFORMATION

Name: ___________________________________________________________________________________

Address: ______________________________________________ Phone: (_______) ____________________

## YOUR PRIVATE HEALTH INSURNACE

Insurance company Name: __________________________________________ Policy #: ________________

Insurance Address: _________________________________________________________________________

Policy Holders Name: ________________________________ Relationship to policy holder _______________

# Auto Accident Information

Patient's Name: ______________________________________ D.O.B: __________________

Date of Accident: _____________________________________ Time: ___________________

Location of Accident: ___________________________________________________________

Description of Accident: ________________________________________________________

Did the police come to the accident? Yes or No     Did the police write a report? Yes or No

Do you have a copy of the report? Yes or No

Where you given a ticket for the Accident? Yes or No

Was the other driver given a ticket? Yes or No

**RESULTS OF COLLISION**

1. Did you loose consciousness?     Yes  No

2. Were you able to get out of the car and walk around by yourself immediately following the accident?   Yes  No

3. Did any parts of your body strike any part of the car?    Yes  No

___________________________________________________________________________

___________________________________________________________________________

4. What were your immediate physical complaints?

___________________________________________________________________________

___________________________________________________________________________

5. Were you treated following the accident?    Yes   No

If yes:

a. How did you get to place of treatment? ______________________________________
b. Were x-rays taken?   Yes  No
c. Treatment received: ______________________________________________________

**FOR OUR FEMALES 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. ____________________

Revised: April 03, 2017 LNF

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: ___________________________________________

This form was approved by the executive board of Prince George's County Medical Society on November 3, 1993, and by the Executive Committee of the Bar Association of Prince George's County on January 11, 1994.

# 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 statue 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: