



Arnaldo A. Garro, M.D., F.A.C.S., F.I.C.S.

BOARD CERTIFIED OTOLARYNGOLOGIST

• Ear • Nose • Throat • Head & Neck Surgery • Endoscopic Sinus Surgery •

www.DrArnaldoGarro.com

(301) 868-8926

PATIENT REGISTRATION

Patient's Name		First	Middle	Last		Date of Birth	Age
Patient's Home Address			Apt No.	City		State	Zip Code
Patient's Occupation				Social Security No	Marital Status	Sex	Patients Home Phone
				<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W			
Patient's Employer				Address			Patients Work Phone
Spouse (or Parent) Name				Spouse (or Parent) Employer			Spouse (or Parent) Work Phone
Spouse (or Parent) Address				City		State	Zip Code
Referring Physician				Address			Telephone

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Our policy is payment is to be made at the time services are rendered unless other arrangements have been made with the Office. Fees for covered SURGICAL and DIAGNOSTIC services will be billed to your insurance carrier. Any unpaid balances are due within 30 days from receipt of insurance payment. If payment is not received within six weeks from the date of service from your insurance carrier, payment in full is due immediately from you.

Preferred Method of Payment: Cash Check Mastercard Visa American express MedCash

The undersigned agrees to promptly pay within 30 days all charges when billed for medical services rendered and the person listed below agrees and does hereby become legally responsible for any and all charges for the patient named above. The undersigned also acknowledges by the signing of this agreement, that should this account become delinquent to the point (120 days or more) that if becomes necessary for Dr. Arnaldo A. Garro, P.A. to refer this account to an attorney or professional recovery services, that a fee of 30% may be added to this account at my expense to cover the fee for this collection.

_____ Responsible Party's Signature

BILLING AND INSURANCE INFORMATION

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SEND BILL TO	First Name	Last Name		Relationship to patient
	Home address	City		State
	Employer	Work Phone		Home Phone
PRIMARY INSURANCE	Insurance Company Name	ID or Policy Number		Group Code
	Insurance Company Address	Subscriber's Social Security		Date Effective
	Insurance Company's Phone Number	Subscriber's Employer Name		
	Subscriber's Name	Relationship to Patient		Home Phone
	Subscriber's Address	Work Phone		Subscriber's Date of Birth
SECONDARY INSURANCE	Insurance Company Name	ID or Policy Number		Group Code
	Insurance Company Address	Subscriber's Social Security		Date Effective
	Insurance Company's Phone Number	Subscriber's Employer Name		
	Subscriber's Name	Relationship to Patient		Home Phone
	Subscriber's Address	Work Phone		Subscriber's Date of Birth

TERTIARY INSURANCE	Insurance Company Name	ID or Policy Number	Group Code
	Insurance Company Address	Subscriber's Social Security	Date Effective
	Insurance Company's Phone Number	Subscriber's Employer Name	
	Subscriber's Name	Relationship to Patient	Home Phone
	Subscriber's Address	Work Phone	Subscriber's Date of Birth

Acknowledgment of Receipt of Privacy Notice	
<p>I have been presented with a copy of Dr. Arnaldo A. Garro's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.</p> <p>Signed: _____ Date: _____</p> <p>If no signed by patient, please indicate relationship to patient (e.g., spouse, etc.)</p> <p>Relationship: _____ Witnessed by: _____</p>	

Internal Use Only:
<p>If patient or patient's representative refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below:</p> <p>Presented on (date and time): _____</p> <p>By: (name and title): _____</p>

PATIENT AUTHORIZATION
<p>I _____ hereby authorize Arnaldo A. Garro, M.D., P.A. to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare, and / or _____ (Name of other Insurance company), be made directly to the above named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).</p> <p>I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.</p> <p>I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to _____ (Name of Medigap Carrier) any information needed to determine these benefits payable for related services.</p> <p>_____</p> <p style="text-align: center;">Date Signature of Subscriber or Beneficiary</p>

We need to make a photocopy of your insurance card(s) for our file. Please give you completed registration form and your insurance card(s) to the receptionist.