

WIMC Fair Oaks
12011 Lee Jackson Memorial Hwy
Fairfax, VA 22033

WIMC Burke
6045 Burke Centre Parkway
Burke, VA 22015

WIMC Fairfax Station
9015 Silverbrook Rd #106
Fairfax Station, VA 22039



Patient Pre-Registration Form

Date: _____

Patient Information

Last Name: _____

First Name: _____

Middle Initial _____

Address : _____

City: _____ State: _____ Zip: _____

Home: (____) _____

Cell: (____) _____

Work: (____) _____

SSN: _____ - _____ - _____

DOB: _____ Age: _____

Gender: M F

** How did you hear about us? Walk-in
 Internet Val pack Yellow Pages
 Post Card HOA Friend/Family
 Print Ad Other _____

EMAIL: _____

Parent/Guardian/Guarantor: Please provide YOUR information if patient is UNDER 18 years of age:

Last Name: _____

First Name: _____

Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: (____) _____

SSN: _____ - _____ - _____ DOB _____

Relationship to patient: _____

Emergency Contact Relationship: _____

Name: _____

Phone Number: (____) _____ - _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Policy Holder Information:

Policy Holder Information:

Last Name: _____

Last Name: _____

First Name: _____

First Name: _____

Middle Initial: _____

Middle Initial: _____

Member ID: _____

Member ID: _____

Group Number: _____

Group Number: _____

SSN: _____ - _____ - _____

SSN: _____ - _____ - _____

DOB: ____ / ____ / _____

DOB: ____ / ____ / _____

Employer: _____

Employer: _____

Relationship to patient:

Relationship to patient:

SELF SPOUSE PARENT CHILD

SELF SPOUSE PARENT CHILD

I hereby authorize Walk-In Medical Care, to release my Protected Health Information as described below: (check appropriate boxes)

- Yes No Complete Medical Records
Yes No History and Physical (to include progress notes and consult notes)
Yes No Labs, X-rays, EKG etc.
Yes No STD-related information
Yes No Psychological reports
Yes No Developmental information
Yes No Other indicate

To: _____

This authorization is effective until I revoke it in writing.

As a courtesy to the patient, we will file the insurance claim with your insurance company, but you must understand that our relationship is with the patient and not the insurance carrier. The patient/guardian is the sole responsible party for all of the charges incurred at the time of visit and guarantees payment thereof. It is not our responsibility to understand the patients insurance plan benefits and/or member responsibilities. These include any deductibles which may be applied to the patients visit and/or obtaining authorizations/referrals required by the patient's insurance company prior to being seen in our clinic. The patient is expected to be fully aware of all aspects of their insurance policy. Failure to provide updated, correct insurance information and/or insurance required authorizations/referrals will result in all charges for services becoming the sole liability of the responsible party.

The treating physician may deem certain tests medically necessary in order to provide the patient with proper medical care. The patient will receive a separate bill from the laboratory for any samples sent to the lab such as blood work, pap smears, cultures, etc. If the patient accepts lab services without getting a required referral or authorization he/she understands that this means he/she will become responsible for this service. Again, it is the patient's responsibility to know what labs, including x-rays, his/her insurance policy does or does not cover and what needs prior authorization and/or a referral.

Consent, Insurance & Information Authorization

I hereby authorize Walk-in Medical Care to apply for benefits on my behalf for covered services rendered by them. I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information to my insurance carrier or me at any time in writing.

I understand and agree to be responsible for any portion of this claim that for any reason is not covered by my insurance. _____ (responsible party's initials)

I understand that any legal fees incurred to collect this claim are my responsibility, as well as any service charges assessed to accounts with returned checks. I further consent that I authorize to be treated by the physicians and medical staff within the Walk-In Medical Care facility. I further certify that the information I provided above is true and correct.

****Patient/Guardian Signature: _____ DATE: _____**

Patient/Guardian Printed Name: _____

*** Please make sure to fill in how you heard about us and sign the form.*