



Eugene J. Louie-Ng, MD, FACOG

Michael S. Liao, MD

Welcome to Lake Manassas Women's Health Associates

Please complete the information below.

Last Name	First Name	Middle Initial	Sex	Date of Birth	SSN
Street Address		Apt, Unit, Suite	City		State Zip
Home Phone	Work Phone	Cell Phone		E-mail	
Marital Status: Single Married Divorced Widowed			How did you hear about us?		
Emergency Contact Name		Relation		Phone Number	

Primary Insurance Information

Insurance Carrier	Policy or ID Number	Group Number	Effective Date
Insurance Carrier Address		Insurance Carrier Phone	Subscriber's SSN
Subscriber's Name		Relation to Subscriber	Sex Date of Birth

Secondary Insurance Information

Insurance Carrier	Policy or ID Number	Group Number	Effective Date
Insurance Carrier Address		Insurance Carrier Phone	Subscriber's SSN
Subscriber's Name		Relation to Subscriber	Sex Date of Birth

Authorization

I certify that the information concerning my insurance coverage is correct. I authorize Lake Manassas Women's Health Associates (LMWHA) to apply for benefits on my behalf under my health insurance policy. I authorize LMWHA to release information, including medical information, necessary to process any claims. I further authorize payment of medical benefits directly to LMWHA. I understand that this signed release is proof that I have approved LMWHA to release any necessary information needed to process any and all claims. This authorization may be revoked in writing at any time.

Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment or proof of valid insurance is due at the time services are rendered unless payment arrangements have been approved in advance by the practice administrator. We accept cash, checks, American Express, Master Card or Visa. We will be happy to process your insurance claim form for reimbursement. To provide this service we must have a fully completed Patient Information form at each visit. We will accept assignment of benefits, but the responsibility of making sure your claims are paid in a timely fashion by your insurance carrier remains with you, the subscriber.

Return checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month. You may also be charged a fee if you do not show up for an appointment or cancel an appointment without giving 24 hours notice. We will gladly discuss the cost of your proposed treatment plan with you; however, you must realize that your insurance is a contract between you, your employer and your insurance company. We are not a party in that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We must emphasize that as healthcare providers, our relationship is with you not your insurance company. We advise treatment based on medical standards of care, not based on what your insurance company will cover. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact the Patient Services Coordinator promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us. We are here to help you.

I understand and agree to the information stated in the **Authorization** and the **Financial Policy**.

Signature

Date