HERCHARAN SETHI, M.D.
1830 TOWN CENTER DRIVE, #309, RESTON, VA 20190
OFFICE PHONE: (703) 476-5200 – ANSWERING SERVICE: (703) 558-0709 – FAX: (703) 476-4707

PATIENT REGISTRATION-PLEASE PRINT CLEARLY

PATIENT NAME First	Middle	Last	Date of Birth	Age
HOME ADDRESS	APT #		CITY STATE	ZIP
OCCUPATION	SOCIAL SECURITY	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX	HOME PHONE
EMPLOYER	ADDRESS		WORK PHONE	
SPOUSE (PARENT) NAME	SPOUSE (PARENT) EMPLOYER		SPOUSE (PARENT) WORK PHONE	
SPOUSE (PARENT) ADDRESS			PATIENT CELL PHONE	
NEAREST RELATIVE/FRIEND	RELATIONSHIP	HOME PHONE	WORK PHONE	
RELATIVE/FRIEND ADDRESS				
REFERRING PHYSICIAN/HOW DID YOU HEAR ABOUT US	ADDRESS	TELEPHONE		

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

Payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment. Payment is accepted in the form of cash, check, credit card or money order. Preferred payment method: ☐Cash ☐ Check ☐ Other (specify)

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above:
X_____

BILLING ANDINSURANCE INFORMATION

SEND BILL TO	FIRST NAME	LAST	RELATIONSHIP TO PATIENT
HOME ADDRESS	CITY	STATE	
EMPLOYER	WORK PHONE	HOME PHONE	
PRIMARY INSURANCE	INSURANCE COMPANY	NAME ID/POLICY #	GROUP/CODE
INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE	
SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH	
SECONDARY INSURANCE	INSURANCE COMPANY	NAME ID/POLICY #	GROUP/CODE
INSURANCE COMPANY	NAME ID/POLICY #	GROUP/CODE	
INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY	DATE EFFECTIVE	
SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH	

PATIENT AUTHORIZATION

I,_____, hereby authorize H. Sharon Sethi, M.D.\United Medical Labs to apply for benefits on my behalf for covered services rendered. I requested payment from BC/BS National Capital Area, Blue Shield of Virginia, Medicare, and/or_____ Insurance Company, be made directly to the above named provider case of Medicare Part B benefits, to myself or the party who accepts assignment). 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 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 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.

_____ _____
DATE SIGNATURE OF SUBSCRIBER OF BENEFICIARY

ACCT # _____