MARGIE CORNEY, M.D., F.A.C.O.G. GYNECOLOGY

Patient Name			
Street Address			
City	State	Zip	Personal E-mail
Soc Sec #	Date of Birth		Marital Status
Home Phone	Cell Phone		Work Phone
Emergency Contact Name	Relationship		Phone
Preferred Pharmacy	Location		Phone
Referring Doctor/PCP			Phone
How did you hear about our office? (Internet, friend, doctor, patient. If from a patient please give name so that we may thank her.)			

Guarantor Information (financially responsible for the patient's account-Please complete only if different than patient.)

Name		Relationship
Address		
City	State	Zip
Soc Sec #		Date of Birth
Home Phone	Cell Phone	Work Phone

Insurance Information

Insurance Company (Primary)	Insurance Company (Secondary)
Subscriber/Sponsor Date of Birth	Subscriber/Sponsor Date of Birth
Policy/Member ID Group #	Policy/Member ID Group #

I hereby authorize the office of Margie Corney, MD, PC to bill my insurance(s) and assign payment of such monies to be sent directly to the provider. I also understand that i am ultimately responsible for payment of any charges for services rendered by the providers of care at Margie Corney, MD, PC and agree to pay any and all balances that are not covered by my insurance carrier(s). Furthermore, i understand that if i fail to pay any balance due the practice, that my account will be turned over to a collection agency or attorney and that i am responsible for up to 33% collection costs in addition to my balance.

I authorize this office to release any information necessary to expedite insurance claims. I understand that i am notice of deemed consent for infectious disease testing: Virginia code section 32.1-45.1 provides that when either a person providing health care service or a patient is directly exposed to the body fluids of the other in a way that may transmit human immune-deficiency virus (which causes acquired immune deficiency syndrome, of aids), of hepatitis b or c virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

I have received and read the financial policy of the office of Margie Corney, M.D., P.C. (please initial)_____

Patient, parent, or guardian _____Date: mth _____day _____ yr_____