Welcome to Our Office

Harne, Song, & Woo, M.D., P.A.
Gary Harne, M.D. James Song, M.D. Kenneth Woo, M.D.
2007 Rock Spring Road **464 Alliance Street**
Forest Hill, MD 21050-2620 **Havre de Grace, MD 21078**

PATIENT INFORMATION Patient's Name:

_____
(Last) *(First)* *(Middle Initial)*

Address:_____
*(Street – **NO** **P.O. Box Please**)* *(City)* *(State)* *(Zip Code)*

Home Telephone: _____ Work Telephone:_____ Day or Evening
(Circle one or both)

Cell/Mobile: _____ Birth Date:_____/_____/_____ S.S. No.:_____-_____-_____
(Month) *(Day)* *(Year)*

Sex: F / M Race:_____ Preferred Language: _____
(Circle) ***(Required by MD Dept of Health)***

Email Address: _____

Spouse's Name:_____ Work Telephone:_____

Emergency Contact:_____ /_____ Telephone:_____
(Relationship to patient)

PATIENT EMPLOYMENT

Occupation:_____ Employer:_____

Supervisor's Name_____ Telephone:_____

MEDICAL INSURANCE "Please list the insurance provided through **your employer** as the **Primary** Insurance Company"

Primary Care/Referring Doctor:_____ Telephone:_____

PRIMARY INSURANCE COMPANY:_____

Policy Holder's Name:_____ /_____
(Relationship to Patient)

Patient's Policy No.:_____ Group:_____

Policy Holder's Birth Date:_____ Co-pay amount:_____

Policy Holder's Employer:_____ Employer's Telephone:_____

Do you or your spouse have other health insurance? ☐ Yes ☐ No If yes, please provide below (use back for additional info).

SECONDARY INSURANCE COMPANY:_____

Policy Holder's Name:_____
/_____
(Relationship to Patient)

Patient's Policy No.:_____ Group:_____

Policy Holder's Birth Date:_____ Co-pay amount:_____
(if applicable)

Policy Holder's Employer:_____ Employer's Telephone:_____

OVER ----->

FINANCIAL POLICY FOR HARNE, SONG AND WOO, M.D., P.A.

Thank you for choosing us as your health care provider. We are committed to your health and successful treatment. Please understand that payment of your bill is very important, as it allows us to continue providing you with the highest and most caring level of service. The following is a statement of our Financial Policy, which we require that you read and sign prior to your treatment.

- It is your responsibility to supply this office with your current address, employment and insurance information, a copy of your insurance card and other forms or a referral from a doctor when necessary.

- If any of the above information changes, **you** must notify us immediately.

- If you have insurance with whom we participate, we will submit the claim for you. **You will be responsible for payment of any copayments, coinsurance or deductible at the time services are rendered**. We cannot guarantee your eligibility or benefits. However, we will work with you and your insurance company to help you understand your policy, its limitations and your financial responsibility.

- We may participate with your insurance company in a special provider agreement and your cost of liability is determined by the fee schedule set forth by your insurance company.

- Once your primary insurance has paid the claim, if you have secondary insurance, we may elect to bill them the full balance due on your account. If your secondary insurance does not pay within 30 days, we will expect you to pay the balance of your bill upon request.

- If you have no insurance or elect to self-pay your account, payment is due at the time service is rendered, unless other arrangements are made **in advance** with the insurance/ billing staff.

- We offer several payment methods, including: check, cash and credit card (Visa, Master Card, Discover and American Express). Full payment is expected within 90 days, unless there are extenuating circumstances.

- If you are having difficulty paying, it is your responsibility to work out a flexible payment schedule with our billing staff. We are always willing to help you and remain responsive to your financial needs. Our goal is to help you meet your financial responsibilities, without causing you financial hardship.

- If you have any questions or concerns regarding our billing policy, please do not hesitate to ask our billing/insurance staff. Remember, the doctor concentrates only on your medical needs. The billing/ insurance staff will discuss your financial arrangements.

I hereby certify that I (or my dependent) assign directly to Harne, Song & Woo, M.D., P.A., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance, including late fees and collection expenses. Returned check fee is $35.00; late fee is 1.5% per month (18% per year); collection fees equal 35% of the balance plus court fees and interest.

I authorize any physician, hospital, insurance company, employer, or organization to release the information necessary to secure treatment or payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Patient and/or Guarantor (SEAL) Date