39070 John Mosby Hwy, PO Box 107 Aldie VA 20105
Phone: (703)327-2434 Fax: (703)327-2729
www.heymanhealth.com IntegrativeMedicineClinic@gmail.com

Patient Name:____

Date of Birth: ___________________ **Medicare Eligible:** ___ yes___no

E-mail address: ____

Address: ______________________________City___________________

State:____________________________Zip Code____________________

Cel Phone:___________________ Home Phone:____________________

Best phone number to contact:________________________________

May we leave a message?________________________

Emergency Contact (name and number):___________________________

Please list any individuals that we may discuss your medical information :

____

Gender: ____Male______Female Marital Status:_________________

Occupation:____

Please note: Full payment is required at the time of service. WE DO NOT PARTICIPATE WITH ANY INSURANCE PLANS. Patients are responsible for filing their own insurance claims. A receipt for services will include the insurance codes necessary for he filing process. The Virginia Center for Health and Wellness is not responsible for any insurance denial or partial reimbursement. Please check with your insurance regarding coverage for any tests or labs that your doctor might order.

Medicare patients are hereby informed that we have OPTED OUT of the Medicare program. Medicare patients are required to inform The Virginia Center for Health and wellness should they become eligible for the Medicare program.

If you are Medicare eligible, please complete the opt out form.

I have read the previous statements and understand that full payment is expected at the time of service.

Date:_______________ Signature: _______________________________

While we do not participate in insurance plans, some of the tests our doctors order might be covered by your plan. Please provide your insurance information **FOR REFERENCE ONLY**.

insurance provider:____

member number:____

group number:__________________ insurance phone:_______________