❑ New Patient

❑ Update

Medical Associates of Reston, Ltd.
1800 Town Center Drive, Suite 212
Reston, VA 20190
703-435-2227

❑ **Lynne L. Fagan, M.D.**
❑ **Gwilym Parry, M.D.**
❑ **Tessa Cholmondeley, M.D.**
❑ **Julie L. Farley, M.D.**

PATIENT REGISTRATION

Patient Name: First Middle Last				Home Phone		
Home Address		City		State	ZIP	
Employer	Address			Cell Phone	Work Phone	
Occupation	Social Security No.		Marital Status S M D W	Date of Birth	Age	Sex M F
Preferred Pharmacy:	Pharmacy Information (city, state. phone number)			E-mail Address		
In Case Of Emergency, Contact:			Phone			
Allergies			Referred by			
Spouse's Name	Spouse's Employer			Work Phone		
Financially Responsible Person Patient Spouse Parent Other	Name (If Different From Patient)		Home Phone		Work Phone	
Financially Responsible Person's Address (If Different From Patient)						

Medicare	Other Insurance
I.D No.:____________________ Effective Date______________	Ins Co Name______________________________ Address__________________________________ City, State, ZIP___________________________ I.D. No:__________________________________ Group___________________________________ Subscriber_______________________________
Medicaid	
I.D. No:____________________	

WE REQUEST PAYMENT AT THE TIME OF SERVICE FOR ALL SERVICES RENDERED.
PLEASE READ AND SIGN BELOW.

I consent to the evaluation and treatment by the physicians and staff of Medical Associates of Reston.
I understand and agree that I am financially responsible for all charges whether or not covered by insurance.

I hereby authorize Medical Associates of Reston (MAR) to release any necessary information, including medical information for this or any related claim, to my insurance carrier (or, in the case of Medicare Part B benefits to the Social Security Administration and the Health Care Financing Administration) or, in the case of workers compensation, to my employer in order to settle medical claims on my behalf.

In the event that MAR submits a claim, I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to the physician who rendered services. I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked either by me or by the above named carrier at any time in writing.

Signature____ Date______________________