NEW PATIENT INFORMATION
J L Fristad, PLLC
512 Herndon Parkway, Suite F, Herndon, VA 20170-5244

Client Name		MR Number
Address	City	Zip Code
Home Phone	Cell Phone	
May we leave a message on your home phone? _____Yes _____No	May we leave a message on your cell phone? _____Yes _____No	
Gender	Age	Date of Birth
Marital Status	Occupation	
Primary Insurance Information		
Insurance Company		
ID/Policy No.	Group No.	
Name of the Insured/Subscriber		Subscriber Date of Birth
Insured Subscriber/Employer		
Social Security Number	Effective Date of Insurance	
Secondary Insurance Information (If applicable)		
Insurance Company		
ID/Policy No.	Group No.	
Name of the Insured/Subscriber		Subscriber Date of Birth
Insured Subscriber/Employer		
Emergency Contact		
Name	Phone	Relationship
Parent/Legal Guardian (for minors)		
Mother/Legal Guardian	Phone	Relationship
Father/Legal Guardian	Phone	Relationship

If you want us to bill your insurance, please provide us with your insurance card and picture ID before or during your first visit. It is important that you understand and agree to the following items for the J L Fristad, PLLC practice. Please initial after each item.

____	I am responsible for my own preauthorization for services from my insurance company. If failure to do so results in non-payment for services by my insurance company, then I understand I will be responsible for payment of theses services.
	I am responsible to pay for all deductibles, co-pays, co-insurance, and any balance when the insurance company has paid its portion and contractual adjustments have been made to my account.
____	I understand that the ultimate responsibility is mine, and verification of insurance is not a guarantee of payment.
____	If I fail to show up for appointments (without calling) or if I cancel or reschedule more than 3 appointments in a 6-month period of time, then I may be discharged as a patient.

I authorize release of any medical or other information necessary to process my claims. I have read and understand all of the above statements. I authorize that payment of benefits to be made on my behalf to J L Fristad PLLC for any services rendered.

Client Signature	Date:
Parent/Legal Guardian Signature	Date:
Clinician Signature	Date: