

**Johns Hopkins University - DACI REFERENCE LABORATORY  
PROFESSIONAL FEE PATIENT REGISTRATION FORM**



**CONSENT & ASSIGNMENTS - *Please Read Before Signing***

- MEDICARE — I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I have read and signed the Advance Beneficiary Notice (ABN). I understand that I am responsible for any health insurance deductibles and co-insurance.
  
- BLUE SHIELD OF MARYLAND — I understand the charge of a non-participating physician may exceed the Blue Shield of Maryland, Inc. payment, and if greater, I will be responsible for that amount. I authorize release of any medical information necessary to process this claim. If managed care, I have read and signed the Managed Care Release Form.
  
- LEGAL ASSIGNMENT — The undersigned expressly agrees that if, upon default, this matter is referred to an attorney for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith.
  
- INSURANCE ASSIGNMENT — I authorize and assign payment directly to the laboratory involved in my treatment or my child's treatment and authorize release of medical information necessary to process the claim. I further understand I am financially responsible for charges not covered by my insurance.
  
- HMO — The DACI Reference Laboratory does not participate in HMOs. Prepayment of tests is required, and the Johns Hopkins Contract for Medical Services must be signed.

**SIGNATURE OF PATIENT, RESPONSIBLE PARTY, PARENT OR LEGAL GUARDIAN**

SIGN  
HERE 

DATE \_\_\_\_\_  
SIGNED \_\_\_\_\_

NOTICE: Anyone who misrepresents or falsifies information requested by this form may upon conviction be subject to a fine and imprisonment under Federal Law.

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PATIENT INFORMATION			
NAME - Last	First	M.I.	DATE
MEDICAL RECORDS NO.	SOCIAL SECURITY NO.	DATE OF BIRTH	SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		MOTHER'S MAIDEN NAME FATHER'S NAME	RACE
PATIENT ADDRESS (1)			

PATIENT ADDRESS (2)			COUNTY OF RESIDENCE
PATIENT'S CITY	STATE	ZIP CODE	PATIENT'S TELEPHONE NO. ( )

EMPLOYMENT INFORMATION			
PATIENT EMPLOYER	OCCUPATION	PHONE NO. ( )	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE

GUARANTOR INFORMATION			
NAME OF PERSON RESPONSIBLE FOR BILL - last	first	m.i.	RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER
GUARANTOR ADDRESS			SOCIAL SECURITY NO.
GUARANTOR CITY	STATE	ZIP CODE	HOME PHONE NO. ( )
GUARANTOR EMPLOYER			GUARANTOR EMPLOYER PHONENO. ( )
SIGNATURE OF PATIENT			

INSURANCE COMPANY - PRIMARY			
NAME			PHONE NO.
ADDRESS			
CITY		STATE	ZIP CODE
CARDHOLDER NAME - last	first	m.i.	RELATIONSHIP TO INSURED CARDHOLDERS DATE OF BIRTH
POLICY NO.	GROUP NO.	PLAN OPTION	
EFFECTIVE DATE	EXPIRATION DATE	HMO AUTHORIZATION NO.	SITE NO.

INSURANCE COMPANY - SECONDARY			
NAME			PHONE NO.
ADDRESS			
CITY		STATE	ZIP CODE
CARDHOLDER NAME - last	first	m.i.	RELATIONSHIP TO INSURED CARDHOLDER'S DATE OF BIRTH
POLICY NO.	GROUP NO.	PLAN OPTION	
EFFECTIVE DATE	EXPIRATION DATE	HMO AUTHORIZATION NO.	SITE NO.

PHYSICIAN INFORMATION			
REFERRING PHYSICIAN	ADDRESS		MEDICARE PROVIDER NO.
JOB RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF ACCID./INJURY	WORKER'S COMPENSATION - CARRIER NAME & ADDRESS	CLAIM NO.
DO YOU HAVE MARYLAND BLUE CROSS MAJOR MEDICAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		DO YOU HAVE BLUE SHIELD SUPPLEMENTAL COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	