Allison Win MD, LLC.

2401 Research Blvd
Suite 102
Rockville, MD 20850
Phone: (240)-224-7519 Fax: (240)-224-7596

Welcome to the practice of Allison Win MD LLC. We look forward to providing your health care.
Office hours are from Monday-Friday from 8:00am to 12 noon and from 1:00pm to 4:00pm. Office will be closed on National Holidays. Should you require health care after hours and holidays, please call our office phone number and a recording will tell you how to contact the physician.

All new patients need to complete the following forms:

Patient Registration Form- be sure to document all information and sign as a responsible party so that we may bill your insurance carrier.

Health History- be sure to complete all pages and sign.

Record Request Form- we must have either an address or phone number of your previous provider.

General Consent for Treatment- to be completed for all patients seeking treatment at this office.

Consent to Treatment of minors/incapacitated person- to be completed by the parent or the legal guardian in case a child or a person who is unable to consent for treatment.

Office Policies- please read the form completely prior to signing.

Federal Privacy Act- this form allows you to indicate the person(s) you wish to keep informed about the condition of your health. Should any person(s) not indicated in this form call, or come to this office to inquire about your health, we will NOT be able to give any answers.

Thank you for choosing us to provide your healthcare. We are committed to providing your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following statement is our financial policy, we require that you read and sing it prior to any treatment being provided.

Office Policies for Allsion Win, MD LLC.

The office accepts cash, checks, credit cards, debit cards and money orders.

Private Insurance: As a courtesy to all our patients we will bill your insurance for you. We require that you pay your copay, share of cost or deductibles at the time of your service. Copayment's must be paid prior to seeing the healthcare provider. We regret that if you do not have your copayment at the time of your service, your appointment will be rescheduled. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide us with the necessary information and correct information. Your insurance policy is the contract between you and your insurance company; we are not a party to that contract.

Please be aware that some or all services provided may be considered non covered or not reasonable and necessary under your policy. If your insurance company has not paid your account in full within 60 days, the balance is your responsibility.

Medicare: We will bill both Medicare and your secondary insurance for your services. If your insurance company has not paid your account in full within 60 days, the balance is your responsibility. You may be responsible for payment of services that are not covered by benefits, example cosmetic, preventive and/or telephone services.

Medicaid/Medicaid Managed Care Organization Insurance: you will be rescheduled if your insurance is not eligible at the time of your service.if your insurance company has not paid your account in full due to lack of insurance at the time of service, the balance is your responsibility.

_____ INITIAL.

Missed Appointments: We ask that you cancel your appointment at least 24 hours in advance.

Returned Check Fee: You will be charged $30.00 in addition to the amount of the check for any check returned as a non-sufficient fund or written on a closed account. In the event of a returned check you may be asked to make all future payments in cash or by money order.

Letter/Form Fee: due to time required to complete forms and to prepare letters, there is a fee of $10.00 for each document requested. This fee cannot be billed to your insurance carrier and must be paid at the time of your request. There will be a minimum of five days to complete the forms and the letters.

Prescription Refills: please plan and allow our office/physician a minimum of five working days to refill your medications. The healthcare provider will not refill/prescribe any antibiotics, pain medications, controlled medications without seeing patients in the office.

For the Controlled Medication: Change in prescription/refills will only be made during scheduled appointments and NOT via phone, at night on weekends or holidays. Patients must schedule an appointment for those medication.

Please bring all medications that you are currently taking in their original containers to each visit. Be sure to include any over-the-counter medications and vitamins or herbal supplements.

Please arrive 15 minutes prior to your scheduled appointment time and bring all the forms with you. Please feel free to request copies of any or all the forms you have completed.

I, the undersigned, have read the above policy and agree to adhere to them as a condition of being treated by this medical practice.

Patient Name (print):_____
Date:_____
Signature:_____

If signed by someone other than the patient, please indicate the relationship.
* Parent or Guardian of Minor Patient:_____
*Guardian or Conservator of Incompetent Patient:_____
*Other:_____