**Vani Rao MD PLLC**

**1020 19th Street, NW Suite 625, Washington DC 20036**

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**Demographic Information**

**Last Name: First Name:**

**Middle Initial: Date of Birthday: --/--/----**

**Home Address:**

**City: State: Zip:**

**Email: Home Phone:**

**Work Phone: Cell Phone:**

**Emergency Contact: Relationship:**

**Emergency Contact Phones:**

**Referral Source: Primary Care Physician:**

**Physician Phone: Last Visit:**

**Pharmacy Name and Location:**

**Pharmacy Phone:**

**Insurance Name: Policy Number:**

**Do you have Medicare? Yes No**

**Dr. Rao has opted out of Medicare, therefore, those individuals with Medicare who wish to see her cannot submit claims to Medicare and must sign an agreement stating an understanding of this.**

I have read the "Fees and Payment Policies" handout and understand that I am responsible for full payment at the time of service, that Dr. Rao does not participate with any insurance companies, and that **I will be charged for phone appointments, any missed appointments, and appointments cancelled with less than 48 hours of notice.**

**Signature**