WASHINGTON ORTHOPAEDICS
& SPORTS MEDICINE
5454 Wisconsin Avenue
Suite 1000
Chevy Chase, MD 20815
Phone: 301.657.1996
Fax: 301.951.6160

2021 K Street, NW
Suite 516
Washington, DC 20016
Phone: 202.833.1147
Fax: 202.296.2515

5215 Loughboro Rd NW
Suite 200
Washington, DC 20016
Phone: 202.787.5601
Fax: 202.787.5606

Richard W. Barth MD
Hand, Wrist, Elbow & Upper Extremity

Marc D. Connell MD
Sports Medicine, Arthroscopy & Joint Replacement

Richard M. Grossman MD
Sports Medicine, Arthroscopy & Adult Reconstruction

Randall J. Lewis MD
Joint Replacement & Adult Reconstruction

Edward G. Magur MD
Foot, Ankle General Orthopaedics & Arthroscopy

David P. Moss MD
Hand, Wrist, Elbow, & Upper Extremity

Jonas R. Rudzki MD
Sports Medicine, Arthroscopy Shoulder, Elbow, and Knee

Benjamin S. Shaffer MD
Sports Medicine, Arthroscopy Shoulder, Elbow, and Knee

John K. Starr MD
Complex Spinal Reconstruction

Anthony S. Unger MD
Joint Replacement Hip, Knee, and Shoulder

Andrew B. Wolff MD
Arthroscopy and Preservation, Sports Medicine

Stephen S. Hass MD
Physician Emeritus 1975-2009

Carl C. MacCartee
Physician Emeritus 1975-2006

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( ) No Insurance Card Waiver

I, _____, am fully aware that I am being seen without my insurance card. Therefore, the billing department is unable to bill my insurance company for reimbursement of today's visit. Until that information is received, I am responsible for any charges resulting from today's visit.

Signature: **Date:**

( ) No Insurance Waiver

I, _____, am fully aware that I am being seen without health insurance. Therefore, I am responsible for any charges resulting from my visits.

Signature: **Date:**

( ) HMO Insurance Waiver

I, _____, understand that I have an **H-M-O** (Health Maintenance Organization) insurance plan This type of coverage does not reimburse for medical services unless I stay in my insurance network.

Washington Orthopaedics and Sports Medicine, P.A., is not in-network with **ANY H-M-O** Insurance plans. Therefore, I understand that I am fully responsible for all charges incurred at this office,

Signature: **Date:**