PULMONARY ASSOCIATES PATIENT INFORMATION FORM

NAME: ____ AGE______ DATE OF BIRTH_____________

Please Circle: Married Single Widowed Divorced SEX (please circle) M/F SS#__________________

Address______________________________________ City__________________ ZIP ______________

Home PH #________________________ Cell # _________________ Work #_____________________

Email____ Referred ________________________

Emergency Contact _________________________ Ph. #______________ Relationship_______________

1. Race (circle) **American Indian or Alaska Native** **Asian** **Black or African American** **More Than One Race** **Native Hawaiian** **Other Pacific Islander** **Caucasian/White** **Refused to Answer**

2. **Birth Place (State)_________________________ Language Spoken_________________________**

3. **Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Refused to Answer**

MEDICARE AUTHORIZATION FOR SIGNATURE ON FILE

I request that payment of authorized Medicare Benefits be made on my behalf to Pulmonary Associates, P.C. for any services furnished to me by the physician when submitted on approved claim forms or electronically submitted claims. I authorize my holder of medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agent any information needed to determine the benefits payable to related services.

Signature____ Date_________________________

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION:

I hereby instruct and direct my insurance company for payment of medical benefits to Pulmonary Associates, P.C. for services rendered to me by the physician. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balances of said professional service charges over and above this insurance payment. A photocopy of the agreement shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to any insurance company or person involved in my case.

Signature____ Date ______________________

REFERRAL AGREEMENT

This physician's office has notified me that my insurance requires authorization to be seen by a physician specialist. My insurance is likely to deny payment for the services rendered to me if I do not provide a referral from my primary care physician. The physician specialist will bill my insurance for the services, but if my insurance denies payment, I agree to be personally and fully responsible for payment.

Signature____ Date ___________________________