



PATIENT INFORMATION

Please Print

Patient Name _____
First Middle Last

Social Security # _____ Birthdate _____ Home Phone () _____

Minor Single Married Other _____ Cell Phone () _____

Address _____ City/State/Zip _____

Patient/Parent's Employer _____ Work Phone () _____

Employer Address _____ City/State/Zip _____

Spouse/Parent's Name _____

Referring Doctor _____ City/State _____

Emergency Contact _____ Phone () _____
Relationship

Email Address _____

RESPONSIBLE PARTY (If other than patient)

Name _____ Relationship to Patient _____

Address _____ City/State/Zip _____

Home Phone () _____ Work Phone () _____ Birthdate _____

Drivers License # _____ Social Security # _____
(photocopy required)

INSURANCE INFORMATION

Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Work Phone () _____

Insurance Company _____ Group # _____ ID # _____
(photocopy required)

Please complete the following if you have a secondary insurance or supplemental plan.

Name _____ Relationship to Patient _____

Name of Employer _____ Work Phone () _____

Insurance Company _____ Group # _____ ID # _____
(photocopy required)

I hereby consent and assign Suburban Lung Associates to furnish any and all records concerning my diagnosis and treatment to my insurer or other health care provider. A photocopy or fax of this consent shall be as valid as the original. I also assign benefits for all providers to Suburban Lung Associates.

I, the undersigned, acknowledge that I am financially responsible for professional services, procedures and tests performed at any of our office locations or in the event of hospitalization. I also give my permission for my treatment to be discussed with my family member or other care giver. Please list names:

 Patient Signature (guardian required if under 18) Patient Name (please print) Date

REGISTRATION AND FINANCIAL POLICY

Thank you for choosing *Suburban Lung Associates* as your medical specialist. We are committed to providing high-quality, cost-effective health care. As part of our service to you and your family, we have summarized your financial responsibilities below.

INSURANCE

Our staff will file your insurance claim, for covered services, including Medicare, Public Aid and Worker,s Comp. We appreciate in over 40 health plans, however it is your responsibility to verify coverage **PRIOR** to your appointment. We will hold incomplete claims for 5 business days only. If you have not provided accurate information within 5 business days the full amount will be your responsibility. A copy of your driver,s license and insurance card(s) will be made upon registration.

REFERRALS

We **DO NOT** accept faxed referrals. You **MUST** bring an original referral to you appointment. If you do not have the required authorization, you will be asked to sign a referral waiver. This places you responsible for the full amount due until an original referral is received.

DEDUCTIBLES AND COPAYS

Many health plans require the patient to meet an annual deductible and often have routine copays for physician services. Check with your health insurance for specific details on the amount. Deductibles and copays are due at the time of service.

PAYMENT

Patient balances will be collected at the time of service. For your convenience we accept cash, check, or credit card (Master Card, VISA, Discover). A \$15.00 charge will be assessed for all checks returned for “Insufficient Funds.”

PAST DUE BALANCES AND COLLECTIONS

Our staff will assist you in making payment as easy as possible. Although we understand emergencies and hardship, we have a legal responsibility to collect on overdue accounts. Please contact the patient Accounts Department if you have extenuating circumstances. Payment arrangements for financial hardship may be considered but not guaranteed. Accounts more than 6 months old may be sent to collections.

MISSED APPOINTMENTS

Certain diagnostic tests require medication to be specifically mixed for each patient. Once mixed, these medications may be not be reused. If you are scheduled for a test in this category and need to reschedule please call at least 24 hours in advance. Otherwise a fee for the medication will be charged to your account.

PROTCARE

A protocare staff member may contact me now or in the future for possible Clinical Research opportunities.

I have read and understand *Suburban Lung Associates Financial Policy*.
Signature indicated on reverse side of form.