# LUNG ASSOCIATES OF SARASOTA
## NEW PATIENT INFORMATION RECORD

## PATIENT INFORMATION (PLEASE PRINT OR WRITE LEGIBLY)

PATIENTS NAME | MARITAL STATUS S M W | DATE OF BIRTH | SOCIAL SECURITY NO.

LOCAL ADDRESS | CITY AND STATE | ZIP CODE | HOME PHONE NO.

OUT OF STATE ADDRESS | CITY AND STATE | ZIP CODE | HOME PHONE NO.

PATIENT'S EMPLOYER | ADDRESS | BUSINESS PHONE NO.

IN CASE OF EMERGENCY CONTACT: | RELATIONSHIP TO PATIENT | PHONE NO.

SPOUSE'S NAME | EMPLOYER | ADDRESS | BUSINESS PHONE NO.

WHO MAY WE THANK FOR REFERRING YOU TO US? | FAMILY PHYSICIAN

E-mail Address for Patient Portal:

## INSURANCE INFORMATION

**I understand I am responsible for authorizations required by my insurance company for follow-up testing and office visits. Initials: _____ Date: _____**

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? | STREET ADDRESS, CITY, STATE AND ZIP CODE | HOME PHONE NO.

I WILL BE PAYING TODAY BY: CASH CHECK VISA/MASTERCARD

PRIMARY INSURANCE | NAME OF POLICYHOLDER | CERTIFICATE NO. | GROUP NO.

SECONDARY INSURANCE | NAME OF POLICYHOLDER | POLICY NO.

OTHER INSURANCE | NAME OF POLICYHOLDER | POLICY NO.

MEDICARE NO. | MEDICAID NO. | PROGRAM NO. | COUNTY NO. | ACCOUNT NO.

## MEDICARE SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to LUNG ASSOCIATES for any services furnished by the group. I authorize any holder of medical information to release to the Health Care Financing Administration and its agent any information necessary to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE:_____

## FINANCIAL POLICY

Full payment is due at time of visit. We accept cash, checks, or VISA/Mastercard. We offer an extended payment plan with prior credit approval. We accept Medicare Assignment. All deductibles and the 20% co-pay are the responsibility of the guarantor. As a courtesy, we will bill your insurance company for you, but you are responsible for payment if the insurance company hasn't paid within 45 days. Regarding insurance companies with whom we are participating providers, all co-pays and deductibles are to be paid at time of visit. There is a $15.00 service fee for any returned check and an 18% service fee for balances over 120 days. Our detailed financial policy is available for review at your request.

I understand that I am financially responsible for all charges rendered. I have read this information and understand it.

SIGNATURE: _____ DATE: _____