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:

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:______________________

As it appears on your card

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: ______________________

Designation of Health Care Surrogate

Name: ______________________________________

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _______________________________________
Address: ____
City: ____ State: ____________________
Phone: ______________________________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: ______________________________________
Address: ____
City: ____ State: ___________________
Phone: ______________________________________

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: ____
Name: ____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf, or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional):

____
____

____
____

____
____

____
____

Signed ____ Date: _______________________

Witnesses:

1. _______________________________________

2. _______________________________________

At least one witness must not be a husband or wife or a blood relative of the principal.