PATIENT'S NAME	DATE OF BIRTH: / /	AGE:
EMAIL ADDRESS:	CELL PHONE #:	
MAILING ADDRESS:	HOME PHONE #:	
CITY:	STATE:	ZIP CODE:
PATIENT'S EMPLOYER:		OCCUPATION:
EMPLOYER'S ADDRESS:		EMP. PHONE #:
SOCIAL SECURITY #:	CIRCLE MARITAL STATUS: M S D W	
SPOUSE'S NAME: DOB: / /	SPOUSE'S SOCIAL SECURITY #:	
EMERGENCY CONTACT:		RELATIONSHIP:
ADDRESS:	PHONE #:	
PRIMARY CARE PHYSICIAN:	REFERRING PHYSICIAN:	
ONSET OF ILLNESS (DATE):		
	INSURANCE INFORMATION	
PERSON RESPONSIBLE FOR PAYMENT:	HOME PHONE #:	
MEDICARE #:		
OTHER MEDICAL INSURANCE:		
INSURED'S NAME:	INSURED'S ADDRESS:	DOB: / /
GROUP #:	CERTIFICATE #:	PHONE #:
How did you hear about our office? ***Please circle*.** **Magazine Ad, Friend, Doctor, Newspaper, Other: _____________**		

WE ARE PARTICIPATING WITH MEDICARE. IF YOU HAVE A SUPPLEMENTAL INSURANCE THAT CROSSES OVER FROM MEDICARE AND PAYS THE DOCTOR, THEN WE WILL NOT COLLECT THE 20%. IF IT DOES NOT CROSS OVER OR YOU HAVE NO SECONDARY INSURANCE, THEN WE WILL COLLECT THE 20% PLUS DEDUCTIBLE AT THE TIME OF SERVICE. PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO YOUR APPOINTMENT. AN INSURANCE RECEIPT WILL BE GIVEN TO YOU TO SEND TO YOUR INSURANCE COMPANY. THIS OFFICE WILL FILE FOR PROCEDURES AND HOSPITALIZATION.

I GUARANTEE PULMONARY GROUP OF CENTRAL FL PAYMENT ALL CHARGES FOR THE ABOVE NAMED PATIENT IN ACCORDANCE WITH THEIR REGULATION AND CHARGES. IN THE EVENT THAT PULMONARY GROUP OF CENTRAL FL CHOOSES TO BILL MY INSURANCE COMPANY. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO THEM ALL MEDICAL BENEFITS DUE ME UNDER THIS POLICY, IF THE SERVICES ARE NOT COVERED BY MEDICARE OR THE OTHER INSURANCE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND AND AGREE THAT ANY OUTSTANDING BILLS WILL BE MY RESPONSIBILITY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS TO MEDICARE OR ANY OTHER INSURANCE OF WHICH I AM A BENEFICIARY; I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS FROM AN OUTSIDE FACILITY THAT MAY BE REQUESTED TO THE OFFICE.

SIGNED: ____ **DATE: / /**

WITNESS: ____