Respiratory Care and Sleep Medicine

Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing. Please provide your insurance card(s) and a picture ID upon completion of this form.

Social Security___________________**Patient**____

Date of Birth_________________**Address**____

Home Tel # _________________________**Work Tel #** _______________________**Patient Cell #** _________________________

Patient E-Mail___________________________ **Marital Status** ______________ **Employment Status** ___________________

How did you hear about our office? ____

Referring Physician _________________________________**Primary Care Physician** __________________________________

Emergency Contact _______________________________ **Relationship**_________________ **Phone #** ____________________

Spouse's name or other responsible party__________________________________ **Phone #** ____________________________

Pharmacy Name, Phone #, Fax # and address____

Primary Insurance _______________________**Subscriber (Insured) Name** ____________________________________

Subscriber: Date of Birth_________________ **Social Security #** _________________________**Employer**____________________

ID #____________________ **Group Name & #**________________________ **Patient Relationship to Insured**_______________
(Self, Spouse, Child)

Insurance Address____

Secondary Insurance ________________________ **Subscriber (Insured) Name**______________________________________

Subscriber: Date of Birth___________________ **Social Security #** _________________________**Employer**__________________

ID #____________________ **Group Name & #**________________________ **Patient Relationship to Insured**_________________
(Self, Spouse, Child)

Insurance Address____

I understand that I am directly and primarily responsible to Respiratory Critical Care and Sleep Medicine Associates (RCSM) for its customary fee for the services rendered to me by RCSM. I realize that if my insurance company fails to pay or if there is any delay in paying RCSM it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to RCSM that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s). I understand that secondary filing is a courtesy, and if there is no payment or response from insurance company, I am responsible for the balance.

For the services rendered by RCSM, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits to the party who accepts assignment (RCSM). I authorize payment of medical benefits to RCSM. I agree to hold RCSM harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

I understand the office may employ an Advanced Practice Registered Nurse ("APRN") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history. I acknowledge that I have read this authorization and fully understand its contents.

Signature____Date___________________