Pulmonary and Sleep Associates of Huntsville
725 Madison Street • Huntsville, AL 35801
1041 Balch Road, Suite 175 • Madison, AL 35758

INITIALS	OFFICE USE ONLY

Date: _____

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First	MARITAL (S M W D SEP)	DATE OF BIRTH	AGE	SEX

RACE: ❑ AFRICAN AMERICAN ❑ ASIAN ❑ CAUCASIAN / WHITE ❑ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ❑ AMERICAN INDIAN / ALASKA NATIVE ❑ DECLINED ❑ UNKNOWN

PRIMARY LANGUAGE: ❑ ENGLISH ❑ SPANISH ❑ OTHER _____	ETHNICITY: ❑ HISPANIC ❑ NON-HISPANIC ❑ DECLINED ❑ UNKNOWN

ADDRESS	CITY , STATE & ZIP

SOCIAL SECURITY NO.	MAIN PHONE NO. ( )	SECONDARY PHONE NO. ( )	EMAIL

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	RELIGION (OPTIONAL)

EMPLOYERS ADDRESS	CITY, STATE & ZIP

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO. ( )

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE	RELATIONSHIP	HOME TELEPHONE NO. ( )	BUSINESS PHONE NO. ( )

ADDRESS	CITY, STATE & ZIP

REFERRING PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )
FAMILY PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

PERSON RESPONSIBLE FOR BILL: _____
IF OTHER THAN PARENT, S.S.# _____
ADDRESS OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
SECONDARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
OTHER INSURANCE	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Pulmonary and Sleep Associates of Huntsville for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Pulmonary and Sleep Associates of Huntsville to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

Signature: _____ Date: _____

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER

Pulmonary & Sleep Associates of Huntsville

DISCLOSURES & PRIVACY PRACTICES

Patient Name: _____ **DOB:** _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

	Phone Number	OK to leave message with detailed information	Leave message with call-back number only
Home Phone			
Work Phone			
Cell Phone			

I acknowledge that I have received a copy of the Notice of Privacy Practices and that Pulmonary and Sleep Associates of Huntsville may, at its discretion change the terms and conditions of this notice.

(Please Initial) _____

Release of Medication History Authorization:

I give Pulmonary and Sleep Associates of Huntsville permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed as part of my medical records release.

(Please Initial) _____

Pulmonary and Sleep Associates of Huntsville and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

Name	Relationship	Phone Number

Printed Name: _____

Signature: _____ Date: _____

Pulmonary & Sleep Associates
of Huntsville

FINANCIAL POLICY

PSA believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance payment in full is expected at the time of your visit. We do ask for a copy of a picture ID due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **INSURANCE.** We are participating providers with several insurance plans. We will file all insurance claims as a courtesy to you. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay PSA within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayments to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed by PSA are considered covered unless limited by your specific insurance policy.

3. **RETURNED CHECKS** will incur a $50.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $50 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $50 service fee and collections action. All returned checks written to PSA are subject to collections and will be prosecuted by Madison County District Attorney.

4. **BILLING OFFICE:** If you have questions in regard to any of your billing statements, our insurance staff at PSA is available to assist you. CALL 256-883-2110.

5. **CANCELLATIONS OR MISSED APPOINTMENTS**: If you do not cancel your appointment at least 24 hours before, or if you-no-show, we may assess you a $25.00 missed appointment fee that must be paid prior to scheduling another appointment. This charge will not be filed with your insurance.

6. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to PSA for charges not covered by the assignment of insurance benefits. **SELF PAY PATIENTS**. All monies owed are expected on date of service. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. PSA will be happy to assist you with a patient financial arrangement however, the first visit will need to be paid in full prior to any arrangements being made.

7. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby, assign, transfer, and set over directly to PSA sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said office. I authorize PSA to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to PSA. I authorize PSA to release all medical information (including, but not limited to, information on psychiatric conditions, Sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

8. **COLLECTION FEES:** I understand that in the event my account is placed in collections status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the PSA financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ Date:_____

Signature of Patient

ADVANCED CARE PLANNING

Patient Name - _____ **DOB -** _____

This form is intended for you to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy.

Place your initials by only ONE answer:

_____ I do not want to name a health care proxy at this time.

_____ I would like to discuss advanced care planning with my family and will discuss this further with my doctor at a later date.

_____ I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

FIRST Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone: _____ Night-time phone: _____

SECOND Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone: _____ Night-time phone: _____

Patient's Signature: _____ **Date:** _____