THE LUNG & SLEEP CLINIC OF ALASKA, INC.

NEW PATIENT INFORMATION (PLEASE PRINT)

PATIENT NAME	SEX	MARITAL STATUS	DOB	SSN (EVEN IF CHILD)
PHYSICAL ADDRESS		CITY & STATE		ZIP CODE
MAILING ADDRESS IF DIFFERENT		CITY & STATE		ZIP CODE
HOME PHONE	WORK PHONE		CELL PHONE	
EMERGENCY CONTACT NAME			EMERGENCY CONTACT #	
PATIENT OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG	WORK PHONE	
SPOUSE OR PARENT'S NAME	SPOUSE OR PARENT'S ADDRESS (IF DIFFERENT)			
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG	WORK PHONE	
EMAIL ADDRESS				

INSURANCE INFORMATION

PRIMARY INSURANCE	SUBSCRIBER #		GROUP #
INSURANCE ADDRESS			INSURANCE PHONE
NAME OF SUBSCRIBER	SSN	DOB	PHONE
SECONDARY INSURANCE	SUBSCRIBER #		GROUP #
INSURANCE ADDRESS			INSURANCE PHONE
NAME OF SUBSCRIBER	SSN	DOB	PHONE

ALL PROFFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT OR RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL FEES INCLUDING ANY COSTS INCURRED IN THE COLLECTION OF THE FEES, REGARDLESS OF INSURANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THE LUNG & SLEEP CLINIC OF ALASKA TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS. I HEREBY ASSIGN TO THE LUNG & SLEEP CLINIC OF ALASKA ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR AMY AMOUNT NOT COVERED BY MY INSURANCE.

FINANCIAL POLICY ACKNOWLEDGEMENT

I, ________________________________ ACKNOWLEDGE AND AGREE THAT I HAVE READ AND CAN RECEIVE A COPY AT ANY TIME OF THE LUNG & SLEEP CLINIC OF ALASKA, INC. FINANCIAL POLICY.

HIPAA ACKNOWLEDGEMENT

I, ________________________________ ACKNOWLEDGE AND AGREE THAT I HAVE READ AND CAN RECEIVE A COPY AT ANY TIME OF THE LUNG & SLEEP CLINIC OF ALASKA, INC. NOTICE OF PRIVACY PRACTICES.

SIGNATURE____ DATE____________________

LUNG & SLEEP CLINIC
OF ALASKA, INC.

FINANCIAL POLICY

PLEASE READ CAREFULLY! IMPORTANT INFORMATION

The Provider/patient relationship is a partnership based upon mutual trust and confidence. The following is our financial policy. We hope this clarifies the terms of our financial relationship with you, the patient. Should you have any questions, please do not hesitate to ask us for additional information.

Patient Responsibility:

- If you have insurance, ***you must provide the office with the most current insurance information and your insurance card.*** In order for The Lung & Sleep Clinic to file an insurance claim on your behalf you must also furnish your *Social Security Number* with the information you provide. **If you have insurance, but do not have your card or cannot provide the ID #, Group # and billing address, you will be required to pay the charges in full.** Upon receipt of this information, the billing department will submit the claim and once payment has been received you will be refunded appropriately.
- If the insurance company has need of documentation from you about your condition, or the care provided to you, ***you must provide all information requested in a timely fashion. Please remember that you, not your insurance company, are responsible for making sure your bill is paid.***
- ***If you do not have insurance, you must make payment in full at the time of service*** unless arrangements for payments have been requested and approved prior to your appointment date. We accept cash, checks, money orders, and MasterCard or Visa.
- ***You must pay any required CoPay at the time of your clinic visit.***
- You are ultimately responsible for the payment of services provided to you. If you have insurance, your contract is with that company, not with The Lung & Sleep Clinic.
- Financial hardship should never stand in the way of medical care. Please discuss any hardship with our Billing Department earlier rather than later. If a payment plan is requested and approved, ***you must meet all payments on a timely basis.*** Failure to do so will result in immediate action, including but not limited to, reporting your failure of payment to a national credit bureau, and turning the account over to a collection agency. Feel free to speak with our Billing Department if you have any questions.
- If your insurance requires you to have a referral for your medical service at The Lung & Sleep Clinic, ***your primary care physician must authorize your visit.*** ***If you chose to keep the appointment without an authorization number, you will be personally responsible and must make payment in full for all charges related to your visit today. Payment is required at the conclusion of the visit today.*** If your insurance subsequently agrees to make payment on your behalf, you will be reimbursed for any overpayment received. ***If it is subsequently determined by your insurance that an authorization was required but not obtained, you will be held financially responsible for all charges,*** in accordance with The Lung & Sleep Clinic's usual financial policies.

CONSENT FOR TREATMENT

I, ________________________, request the Providers at The Lung & Sleep Clinic of Alaska, Inc to provide medical care for myself, or for _____________________, who is a minor or an incapacitated adult, for whom I have legal responsibility and guardianship. I understand the Providers at The Lung & Sleep Clinic of Alaska, Inc will give medical evaluation of health, and may advise diagnostic or therapeutic treatments and understand their recommendations will be in accordance with their medical knowledge, experience, and national recommendations. I understand the Providers at The Lung & Sleep Clinic of Alaska, Inc will be available to provide care at all times, or have a designated physician to provide coverage for them. I also understand that the Providers at The Lung & Sleep Clinic of Alaska, Inc will attempt to achieve the best medical outcome for my health issues, but I acknowledge that I have been given **no guarantee** of therapeutic outcome.

I am informed and acknowledge that services provided to me at The Lung & Sleep Clinic will be provided by an **Advanced Nurse Practitioner, Physicians Assistant or Physician,** depending on availability, at my visits.

I understand that a patient-Provider agreement is hereby entered into. I understand that it is my responsibility to provide accurate and complete information to my Provider. I also acknowledge that it may be in my best interest to take the recommended tests and medical therapy. I do understand that *I have the right to refuse any tests or treatments* recommended, but I have a responsibility to advise my Provider of my decision and my reasons for declining the recommended action. I also acknowledge that it is my responsibility to keep any recommended follow-up appointments, and that it is my responsibility to call The Lung and Sleep Clinic as soon as possible of any appointments which will need to be rescheduled.

I acknowledge that failure to follow clinical recommendations interferes with quality medical care, and is considered an infringement of the patient-Provider relationship. The Providers of The Lung & Sleep Clinic of Alaska, Inc and staff will attempt to address these concerns if and when they arise. I understand that continued non-compliance with medical recommendations, after several efforts to correct the problem may result in my dismissal as a patient of The Lung & Sleep Clinic of Alaska, Inc.

Protected health information may be used and disclosed to carry out treatment, payment, or healthcare options. You have the right to review the notice of rights before signing this consent. You have the right to request a restriction on how the information will be used or disclosed. The Lung & Sleep Clinic of Alaska, Inc is not required to agree to the request for a restriction. You have the right to revoke this consent in writing.

______________________________ ______________________________

Patient Parent or Legal Guardian (if patient is minor)

Date: ______________________

The Lung & Sleep Clinic of Alaska, Inc.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

As a physician and doctor's office, we come across many situations where family should be contacted on behalf of our patients and where family members have contacted us for information. Because of the current HIPAA laws, we are not authorized to give any information about our patients to anyone without a signed consent from that patient. Therefore to avoid any conflicts or miscommunications please specify below who we as an office are allowed to release information to and the type of information that is authorized for release, ensuring to sign and date the bottom.

☐ Spouse/Significant Other: ______________________________

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☐ Children: ______________________________

____

☐ Guardian's/Parents/Siblings: ______________________________

____

☐ Friend's: ______________________________

____

☐ Case Manager: ______________________________

____

☐ Other: ______________________________

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Do we have permission to leave a message for you?

☐ Yes at: ______________________________

☐ Detailed: ______________________________

☐ Contact Person and Office Name and Number only

______________________________ Sign Here

______________ Date

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