Southeastern Lung Care and The Sleep Disorders Centers

PATIENT REGISTRATION

PLEASE PRINT

TODAY'S DATE / /

PATIENT INFORMATION

LAST NAME	FIRST	MI	ADDRESS	APT #	P.O. BOX

CITY	STATE	ZIP CODE	SEX	AGE	HOME PHONE	CELL OR PAGER	WORK PHONE
					( ) -	( ) -	( ) -

DATE OF BIRTH	EMPLOYER/SCHOOL	MARITAL STATUS	RACE
		SINGLE ❑ MARRIED ❑ DIVORCED ❑ OTHER ❑	CAUCASIAN ❑ BLACK ❑ HISPANIC ❑ MIDDLE EASTERN ❑ ASIAN ❑ OTHER ❑

EMPLOYED	EMPLOYER ADDRESS	SOCIAL SECURITY #	DRIVER'S LICENSE #
YES ❑ NO ❑		— —	

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELL OR PAGER	RELATIONSHIP
( ) -	( ) -	( ) -	

PRIMARY CARE PHYSICIAN OR GROUP NAME

LAST NAME	FIRST NAME	MI	ADDRESS	TELEPHONE
				( ) -

REFERRING DOCTOR OR PARTY OR GROUP NAME

LAST NAME	FIRST NAME	MI	ADDRESS	TELEPHONE
				( ) -

DO YOU HAVE YOUR REFERRAL # FOR VISIT TODAY?	WHICH HOSPITAL DO YOU USUALLY GO TO? ✓ ONE:
	❑ DMC ❑ ROCKDALE ❑ NEWTON ❑ EMORY JOHNS CREEK ❑ OTHER ___________

IN CASE OF EMERGENCY CALL

NAME	WORK PHONE	HOME PHONE	CELL OR PAGER
	( ) -	( ) -	( ) -

IS THIS ACCIDENT RELATED? ❑ YES ❑ NO

WORKER'S COMP. OR AUTO ACCIDENT (CIRCLE ONE) BRIEF DESCRIPTION:	DATE OF ACCIDENT
ATTORNEY NAME:	ATTORNEY PHONE:
ATTORNEY ADDRESS:	

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE

SUBSCRIBER (if other than patient)	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER	PHONE NUMBER	RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE

SUBSCRIBER (if other than patient)	SEX	DATE OF BIRTH

SOCIAL SECURITY NUMBER	PHONE NUMBER	RELATIONSHIP TO PATIENT

PLEASE READ AND SIGN ON BACK OF THIS FORM
AND PRESENT YOUR INSURANCE CARD

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT OF BENEFITS AND CONSENT TO TREATMENT

• I hereby authorize treatment by Southeastern Lung Care & The Sleep Disorders Centers, and the release of any information including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review and/or quality assurance activities and/or to attorneys, upon authorized HIPAA compliant request form.

• I hereby assign and authorize payment to SELC of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

• I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of these fees and charges not directly reimbursed to SELC, by any insurance policy, self-insurance program or other benefit plan.

• The authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Medicare Beneficiary Agreement

I request that payment of Medicare benefits be made to Southeastern Lung Care for services rendered. I understand that I will be notified by SELC if Medicare is likely to deny payment for services and I will be responsible for payment.

By signing below I authorize Southeastern Lung Care physicians and staff to administer medical treatment.

Patient's signature Date

If the patient is unable to sign, please provide the signature of person providing the authorization and their relationship to the patient.

ADVANCED BENEFICIARY NOTICE (ABN)

Note: You will need to make a choice about receiving these health care items or services.

We anticipate that Medicare will not cover the services described below. Medicare does not pay for all healthcare costs. Even though Medicare may generally pay for a specific service, this is based on a case-by-case basis. In order for Medicare to pay for covered services, Medicare rules must be met. If Medicare will not cover a particular service doesn't mean that the service would not be of a benefit to you.

In your case Medicare may not pay for:

For this reason further action is required of you. You must make an informed decision as to whether or not you wish to receive the above-described services, even though you may end up having to pay for them yourself. Before making a decision, please do the following:

1. **Read this entire notice carefully.**
2. **If you do not understand why Medicare may not pay for these services, ask us to explain why.**
3. **Ask us for an estimate of how much these services may cost you if Medicare doesn't pay for them.**

Option 1. Yes, I want to receive these items or services. Please submit my claim to Medicare. You may bill me for services, if Medicare denies payment. I agree to be personally and fully responsible for payment. I understand that I can appeal Medicare's decision.

Signature Date Cost / Signature Date Cost

Signature Date Cost / Signature Date Cost

Option 2. No, I have decided not to receive these items or services. I understand that you will not be able to submit a claim to Medicare and you will not be able to file an appeal.

Signature Date Cost / Signature Date Cost

Signature Date Cost / Signature Date Cost