HYPNOS SLEEP WELLNESS
(800) 888-1426
(605) 271-2277 Fax
6709 S Minnesota Ave
Siou Falls, SD 57108

ACCOUNT # _____

PATIENT INFORMATION

PLEASE PRINT

NAME: _____ (Last / First / Middle) BIRTHDATE: _____

HOME ADDRESS: _____ (Street / City / State / Zip) PHONE: _____

EMPLOYER: _____ WORK PHONE: (_____) _____ SOCIAL SECURITY #: _____

SEX: ❑ MALE ❑ FEMALE MARITAL STATUS: S WID DIV. M (Circle One) PATIENT E-MAIL: _____

AN EMERGENCY CONTACT, OUTSIDE YOUR HOUSEHOLD: Relationship: _____

_____ (Name / Address / Phone)

SPOUSE'S NAME: _____ (Last / First / Middle) BIRTH DATE: _____

EMPLOYER: _____ WORK PHONE: _____ SOC. SEC. NO.: _____

RESPONSIBLE PARTY: (If other than patient) SOC. SEC. NO.: _____

NAME: _____ (Last / First / Middle) SEX: M F (Circle One) BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS: _____ (Street / City / State / Zip) EMPLOYER: _____

PRIMARY INSURANCE COVERAGE

POLICY #: _____

DO YOU HAVE INSURANCE? ❑ YES ❑ NO COVERAGE EFFECTIVE DATE: _____

PRIMARY INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

COVERAGE EFFECTIVE DATE: _____

POLICYHOLDER NAME: _____ POLICYHOLDER SS#: _____

POLICYHOLDER DOB: _____ POLICYHOLDER RELATIONSHIP TO PATIENT: _____

MEDICARE NUMBER: _____ EFFECTIVE DATE: _____

MEDICAID NUMBER: _____ EFFECTIVE DATE: _____

SUPPLEMENTAL/SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY NAME: _____ POLICYHOLDER SS#: _____

INSURANCE CO. ADDRESS: _____ POLICYHOLDER DOB: _____

POLICYHOLDER NAME: _____ POLICYHOLDER RELATIONSHIP TO PATIENT: _____

POLICY#: _____ POLICYHOLDER EMPLOYER: _____

AUTHORIZATION FOR TREATMENT: Realizing that I require medical care, I do hereby voluntarily consent to such medical care encompassing such diagnostic procedures and medical treatment by my physician, his assistants, or his designees including consulting physicians, employees, and students in educational programs affiliated with Pulmonary & Sleep Consultants, as is necessary in the judgement of my physician. I consent to testing for HIV (AIDS) and/or Hepatitis should a health care worker have accidental exposure to my blood or other body substances.

RELEASE OF INFORMATION: I hereby authorize Pulmonary & Sleep Consultants to release diagnostic and procedural information for the completion of insurance claim forms. I hereby authorize the release of clinical information to third party payors and/or their reviewing contractors to comply with preadmission review and continued stay requirements. I authorize the release of clinical information to referring physicians and facilities for the purpose of continued health care.

ASSIGNMENT OF BENEFITS: Authorization is hereby granted for the direct payment to Pulmonary & Sleep Consultants for all benefits payable to me. I understand I am financially responsible for all charges regardless of insurance coverage.

_____ Patient Signature

_____ Patient's Representative

_____ Date

_____ Relationship to Patient