pulmonary & sleep CONSULTANTS

mary WUEBBEN WELLNESS

How were you referred for this visit?
(Circle all that apply)

Friends / Family
Physician referral
Yellow Pages
Hospital
Web Site
Other:_____
Facebook
TV
Presentation
Newspaper
Radio

PATIENT NAME (Please print full Legal Name)

First name _____ MI _____
Last name _____
Prefer to be called _____
Date of Birth ____/____/____ Age _____
( ) Male ( ) Female
Last 4 digits of Social security # _____
Address _____
City _____ State _____ Zip _____
Home phone _____ Cell phone _____
Preferred method of Contact ( ) portal ( ) cell phone
( ) work phone ( ) home phone ( ) mail
Primary care physician _____
Referring physician _____

Preferred Language _____ ( ) Decline

Race ( ) American Indian ( ) Asian ( ) Black ( ) White
( ) Native Hawaiian ( ) Decline

Ethnicity ( ) Hispanic ( ) Non-Hispanic ( ) Decline

Emergency Contact Person _____
Relationship _____
Home phone _____ Cell phone _____

Employer's name _____

Address _____
City _____ State _____ Zip _____
Work phone _____
Occupation _____
If student, School name _____

Patient status
( ) Single ( ) Married ( ) Divorced ( ) Child ( ) Other
If Married, Spouse name _____

Is this Illness / Injury a result of
( ) Accident / Illness that occurred at work
( ) Auto accident
( ) Accident / Illness involving liability
( ) Any other accident / injury
Date of Injury / Accident _____
State in which accident occurred _____

Responsible party _____
Address _____
City _____ State _____ Zip _____
Home phone _____ Cell phone _____
Employer _____
Relationship to patient _____

FOR ALL PATIENTS

PRIMARY INSURANCE INFORMATION

Insurance company name _____
Address _____
City _____ State _____ Zip _____
Policyholder name _____
Policyholder DOB _____
Policyholder Employer _____
Relationship to Policyholder _____
Group # _____ ID# _____

SECONDARY INSURANCE INFORMATION

Insurance company name _____
Address _____
City _____ State _____ Zip _____
Policyholder name _____
Policyholder DOB _____
Policyholder Employer _____
Relationship to Policyholder _____
Group # _____ ID# _____

FOR ALL MEDICARE PATIENTS

Medicare eligibility based on ( ) Age ( ) Disability
( ) End stage renal disease

1. Do you or your spouse work for a company that provides health insurance? ( ) Yes ( ) No
2. Are you a nursing home patient? ( ) Yes ( ) No
3. Has treatment for this accident / illness been authorized by the Veterans' Administration? ( ) Yes ( ) No
4. Are you entitled to benefits under the federal Black Lung Program? ( ) Yes ( ) No

IMPORTANT: PLEASE COMPLETE THE SECOND PAGE

AUTHORIZATION TO DISCUSS TREATMENT

There may be occasions when you want to give another person the ability to discuss your care at Pulmonary & Sleep Consultants / Mary Wuebben Wellness (billing, treatment, appointments, prescriptions, etc.). Examples include spouse, parent (if you are over 18), another family member, adult child, coach, nursing home staff, care provider, etc. This authorization will allow discussion only. It does not authorize the release of medical records. I give my permission for Pulmonary & Sleep Consultants / Mary Wuebben Wellness personnel to share information verbally regarding my treatment with the following person(s).

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (Please check only 1 box)

#1 ( ) The undersigned hereby acknowledges that he / she was offered the Pulmonary & Sleep Consultants / Mary Wuebben Wellness Summary Notice of Privacy Practices and declined a copy.

OR

#2 ( ) The undersigned hereby acknowledges receipt of the Pulmonary & Sleep Consultants / Mary Wuebben Wellness Summary Notice of Privacy Practices and attached Notice of Privacy Practices.

AUTHORIZATION TO PAY PULMONARY & SLEEP CONSULTANTS / MARY WUEBBEN WELLNESS

I authorize payment directly to Pulmonary & Sleep Consultants / Mary Wuebben Wellness of benefits payable under this policy. I understand that I will be financially responsible to Pulmonary & Sleep Consultants / Mary Wuebben Wellness for any charges not covered by this policy. It is the objective of this office to provide our patients with the best available care and facilities at a reasonable cost. In an effort to eliminate the expense of billing and collection, we ask that you pay for these services as they are rendered. A service charge of 1.2% will be added to accounts over 90 days past due. If you have insurance, please understand that this is an agreement between you and your insurance company to pay certain amounts for medical care. Our bill for services is an agreement between you and us. If unusual circumstances should make it impossible to meet our credit terms, please call us personally to discuss the matter with our credit manager. This will avoid misunderstandings and enable you to keep your account in good standing.

AUTHORIZATION FOR PATIENT PORTAL ELECTRONIC COMMUNICATION (Please check only 1 box)

#1 ( ) I agree and consent to receive all forms of electronic communication, including medical records and billing information, sent to me by Pulmonary & Sleep Consultants / Mary Wuebben Wellness.

OR

#2 ( ) I DO NOT consent to electronic communication to and from Pulmonary & Sleep Consultants / Mary Wuebben Wellness .

Email _____

By signing this document, I am authorizing the choices as stated above.

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT (parent, foster parent, attorney, etc.) _____