

**PATIENT NAME (Please print full Legal Name)**

First name _____ MI _____

Last name _____

Prefer to be called _____

Date of Birth ____/____/____ Age _____

() Male () Female

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 _____

How were you referred for this visit?

() Facebook

() Radio

() Friends / Family

() Seminar

() Hospital

() TV

() Local Best

() Wayne & Mary's

() Newspaper

() Website

() Pharmacy Specialty

() Yellow Pages

() Physician referral

() Other: _____

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# _____

IS THIS A WORKMAN'S COMP CLAIM? () Yes () No**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, 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.) _____