KENT PULMONARY ASSOCIATES

Patient Name: _____ Date: _____

Address: _____

Date of Birth: _____ Social Security #: _____ Marital Status: _____

Phone: Home# _____ Work# _____ Cell# _____

Employer: _____ Occupation: _____

Primary Care Physician (First and Last Name): _____ Phone No. _____

Do you have a CPAP or Oxygen? Company Name? _____

Emergency Contact: _____ Relationship to Patient: _____

Phone: Home# _____ Work# _____ Cell# _____

Responsible Party: _____ Relationship to Patient: _____

Address: _____

Date of Birth: _____ Social Security #: _____ Relation to Patient: _____

AUTHORIZATION/ ASSIGNMENT OF BENEFITS:

I give permission To KENT PULMONARY ASSOCIATES and its employees, agents, and medical providers to release medical information to insurance carriers, health organizations, governmental agencies, and other entities charged with fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payment of the medical benefits otherwise payable to me, to be directed to or appropriate provider. I consent to have any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I understand that any or all of my medical information may be used for blind-data research, in which NONE of the data will be linked to my identity. I understand that my medical information may be electronically submitted to any or all treating physicians, hospitals, and/or health care entities. I permit a copy of this authorization to be used in place of the original.

X_____

Signature of Patient or Guardian Relation to Patient Date

FINANCIAL POLICY ACKNOWLEDGEMENT:

I hereby acknowledge that I have fully reviewed and understood the Financial Policy given to me. Furthermore, by signing below, I agree to comply with KENT PULMONARY ASSOCIATES financial policy.

X_____

Signature of Patient or Guardian Relation to Patient Date

HIPAA PRIVACY ACKNOWLEDGEMENT:

I hereby acknowledge that I have received and reviewed the NOTICE OF THE PRIVACY PRACTICES from KENT PULMONARY ASSOCIATES.

X_____

Signature of Patient or Guardian Relation to Patient Date