

CENTRAL FLORIDA PULMONARY GROUP, P.A.

Patient Information For Authorization of Treatment

Office Use Only	
Account:	Date:
<input type="checkbox"/> Hospital <input type="checkbox"/> Mills <input type="checkbox"/> East	

Please Print

PATIENT INFORMATION

Patient Name		Evening Phone	Daytime Phone	Today's Date
Street Address	Apt. No.	City	State	Zip
Martial Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorce		Birth Date	Social Security Number	Gender

SPOUSE/GUARDIAN INFORMATION

Spouse/Guardian Name	Social Security Number	Relationship	Daytime Phone
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EMERGENCY CONTACT

Emergency Contact Name (Not living at same address)	City/State	Relationship	Daytime Phone
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INSURANCE INFORMATION

Patient's Primary Care Physician (PCP)	PCP's Phone	Referring Physician	Referring Physician Phone	Is the patient retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
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If my insurance requires an authorization and it has NOT been obtained, I realize I may be responsible for services rendered. I understand that I am financially responsible for charges rendered and that filing my insurance is a courtesy performed by this office.

Primary Insurance Carrier	Policy Number	Group Number	Employer Name	Effective Date
Claims Address	City	State	Zip	Insurance Phone
Policy Holder's Name	Social Security Number	Birth Date	Relationship to Patient	Daytime Phone
Secondary Insurance Carrier	Policy Number	Group Number	Employer Name	Effective Date
Claims Address	City	State	Zip	Insurance Phone
Policy Holder's Name	Social Security Number	Birth Date	Relationship to Patient	Daytime Phone

Please continue authorization of treatment on the backside.

FOR MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to **Central Florida Pulmonary Group, P.A.**, for any services furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents, any information needed to determine these benefits or these benefits payable for related services. I also request that payment for authorized Medigap benefits be made on my behalf to **Central Florida Pulmonary Group, P.A.** for services provided. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim because my signing this authorization will allow Medicare payment information to cross over automatically. This authorization serves as a lifetime authorization unless revoked in writing by me. A copy of this authorization may be used in place of the original.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

FOR NON-MEDICARE PATIENTS

I authorize release of any medical information necessary to process this claim and related claims. I request that payment of authorized benefits be made on my behalf to **Central Florida Pulmonary Group, P.A.** for any services furnished to me. This authorization serves as a lifetime authorization unless revoked in writing by me. A copy of this authorization may be used in place of the original.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

ALL PATIENTS

I agree to pay all balances owed, including, but not limited to, coinsurance, co-payments, deductible, and non-covered services promptly upon presentation thereof. Balances as shown by statements are agreed to be correct unless protested in writing within thirty days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claim thereon. If your bill remains unpaid, you will be held responsible for all collection costs including collection agency fees. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

CONSENT FOR TREATMENT

The patient and/or authorized representative of the patient whose signature is affixed below does hereby consent to medical treatment which may be deemed advisable by my physician/provider. The intention, hereof, being to grant authority to administer and perform all examinations, treatment, and diagnostic procedures which may now or during the course of my care be deemed necessary.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

PATIENT PERMISSION TO COMMUNICATE MEDICAL INFORMATION

The patient and/or authorized representative of the patient whose signature is affixed below does hereby permit and does not object to the communication of medical information related to my care and condition to the following two individuals (e.g. spouse, son, daughter, friend, etc.)

Name of Individual _____ Relationship _____ Phone Number _____

Name of Individual _____ Relationship _____ Phone Number _____

Patient Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____