

CFPG Patient Information & Authorization of Treatment

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

Please Print

Patient Information			
Patient Name: _____		Birth Date: _____	Today's Date: _____
Phone: Home _____	Cell _____	Work _____	
Email: _____		Social Security Number: _____	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Language: _____	Race: _____	Ethnicity: _____
Address: _____			Apt: _____
City: _____	State: _____	Zip: _____	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
Spouse/Guardian: _____	Social: _____	Relationship: _____	Phone: _____
Emergency Contact: _____	Relationship: _____	Phone: _____	

Pharmacy Information			
Pharmacy Name: _____		Phone: _____	Fax: _____
Address: _____	City: _____	State: _____	Zip: _____

Referring Physician Information			
Physician Name: _____		Phone: _____	Fax: _____
Address: _____	City: _____	State: _____	Zip: _____

Primary Care Physician Information			
Physician Name: _____		Phone: _____	Fax: _____
Address: _____	City: _____	State: _____	Zip: _____

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 Information			
Insurance Name: _____		Phone: _____	Is the patient retired?: <input type="checkbox"/> Y <input type="checkbox"/> N
Address: _____	City: _____	State: _____	Zip: _____
Policy No.: _____	Group Name/No.: _____	Effective Date: _____	
Employer Name: _____		Policy Holder's Name: _____	
Policy Holder's: Social _____	Birth Date _____	Relationship to Patient _____	

Secondary Insurance Information			
Insurance Name: _____		Phone: _____	Is the patient retired?: <input type="checkbox"/> Y <input type="checkbox"/> N
Address: _____	City: _____	State: _____	Zip: _____
Policy No.: _____	Group Name/No.: _____	Effective Date: _____	
Employer Name: _____		Policy Holder's Name: _____	
Policy Holder's: Social _____	Birth Date _____	Relationship to Patient _____	

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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:** _____

Name of Individual: _____ **Relationship:** _____ **Phone:** _____

Beneficiary Signature: _____ **Date:** _____

Authorized Representative Signature (if applicable): _____ **Date:** _____