Montgomery County Pulmonary and Sleep Consultants, PC

609 West Germantown Pike, Suite 210 • East Norriton, PA 19403
Phone: (610) 275-2446 • FAX: (610) 275-3266

Gary S. Drizin, MD, FCCP • Alan S. Josselson, MD, FCCP
Eric J. Shakespeare, MD • Michael S. Lagnese, DO • Joseph S. Demidovich, DO

Dear: _____ Date: _____

Thank you for choosing Montgomery County Pulmonary and Sleep Consultants for your medical needs. ***Please read the following carefully.*** We do not wish to reschedule your appointment or have you wait. We would like your experience with our office to be relaxed and comforting.

Please review the following in preparation for your appointment:

- **Bring enclosed patient information - completed.**
- **Complete Sleep Questionnaire (if applicable).**
- **Bring all insurance information and cards including picture ID.**
- **Ensure Primary Care Physician has issued Insurance Referral.**
  - (If applicable) The physician is not able to see you without the referral. Our office cannot check for this referral before your appointment.
- **If you are being referred by another physician, please bring a referring request from that physician with you. Our physician will be unable to see you without this, due to insurance constraints.**
- **Bring medication list.**
- **Bring X-ray and/or CAT scan films or discs and reports (if applicable).**

Your insurance may also require a co-pay and this is due at time of service with no exceptions.

YOU MUST ARRIVE 15 MINUTES PRIOR to your scheduled appointment to allow time for check-in and confirmation of your registration information. **IF YOU DO NOT ARRIVE ON TIME, YOUR APPOINTMENT MAY NEED TO BE RESCHEDULED.** Please be aware there is valet parking for your convenience at no charge.

Due to an increase in the number of new patients who fail to keep their scheduled appointments or fail to cancel them in a timely manner, we find it necessary to obtain **credit card or a check** for new patients to hold the appointment. **A fee of $75.00 will be charged to your card if you do not come for the appointment or fail to cancel forty-eight (48) hours prior to the scheduled time. In the event your credit card is invalid, this fee will be charged to you.**
Facility patients require a family member and/or medical aide from facility.

If you have any questions, please feel free to call our office at any time.
Thank you and we look forward to being of service to you.

Physicians and Staff of Montgomery Pulmonary and Sleep Consultants

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Today's Date _____

PATIENT REGISTRATION

Last Name _____ First _____ MI _____

Address _____

City _____ State _____ Zip _____

Daytime Phone _____ Alternate Phone _____

Date of Birth _____ Social Security # _____

Sex _____ Marital Status _____ Race _____

How did you hear about us _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Employer Phone _____

Emergency Contact _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship to Patient _____

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MEDICARE PATIENTS ONLY

In compliance with Medicare Regulations, we are required to ask the following:

	✓check box
Do you or your spouse work for a company that provides you with **health insurance**?	☐ Yes ☐ No
Are you entitled to Medicare because of **disability** or **end stage renal disease**?	☐ Yes ☐ No
Is the illness or injury the result of an **automobile accident or other injury**?	☐ Yes ☐ No
Has treatment for the accident or illness been authorized by the **Veterans Administration**?	☐ Yes ☐ No
Are you entitled to any benefits under the **Federal Black Lung Program**?	☐ Yes ☐ No

I certify that this information is true and complete to the best of my knowledge. I request payment authorized Medicare/Medigap benefits be made for me or on my behalf to Montgomery County Pulmonary and Sleep Consultants, P.C. for any services furnished to me by the physicians at Montgomery County Pulmonary and Sleep Consultants, P.C.

Signature of Medicare Beneficiary

Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. With my consent, Montgomery County Pulmonary and Sleep Consultants, P.C. may use and disclose Protected Health Information (PHI) about to carry out treatment, payment and Health Operations. Please refer to Montgomery County Pulmonary and Sleep Consultants, P.C. Notice of Privacy Practices for more complete description. I acknowledge that I have reviewed and/or received a copy of this notice.

2. I have the right to review the Notice of Privacy Practices prior to signing this consent. Montgomery County Pulmonary and Sleep Consultants, P.C. reserves the right to revise its Notice of Privacy Practices at any time. If revised, a notice to this effect will be posted in the office and an updated copy will be available to me. I may request a written revised copy sent to my home via mail if formally requested in writing to Montgomery County Pulmonary and Sleep Consultants, P.C., 610 W. Germantown Pike, Suite 210, East Norriton, PA 19403.

3. With my consent, Montgomery Pulmonary and Sleep Consultants, P.C. may call my home or other designated location and leave a message on voice mail answering machine or in person in reference to any items that assist the practice of carry out Treatment, Payment or Healthcare Options.

4. With my consent, Montgomery Pulmonary and Sleep Consultants, P.C. may mail to my home or other designated location any items that assist the practice in carrying out Treatment, Payment or Healthcare Options as long as they are marked Personal and Confidential.

5. I have the right to request emails to myself or request Montgomery County Pulmonary and Sleep Consultants, P.C. to restrict how it uses or disclosed my PHI.

Signature of Patient _____ Date _____

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CONSENT TO TREAT

I consent to the consultation/treatment/evaluation and management by the physicians at Montgomery County Pulmonary and Sleep Consultants, P.C.

I assign all third party insurance benefits to Montgomery County Pulmonary and Sleep Consultants, P.C.

As a courtesy to our patients, it is the policy of this office to bill your insurance for you. However, all copays, co-insurances and deductibles as well as any/all non-covered services are the responsibility of the patient and/or guarantor. This is due at the time of your visit, unless other arrangements have been made.

Signature of Patient or Responsible Party

Date

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PRIVACY OF HEALTH RECORDS
PROTECTED HEALTH INFORMATION

By signing this form, I am consenting to Montgomery County Pulmonary and Sleep Consultants, P.C. use and disclose of my Protected Health Information to carry out treatment to the following individuals as well as my insurance company.

NAME	RELATIONSHIP	PHONE NUMBER

I hereby acknowledge that I have reviewed and/or received a copy of the Notice of Privacy Practices for Montgomery County Pulmonary and Sleep Consultants.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Montgomery County Pulmonary and Sleep Consultants P. C. may decline to provide treatment to me.

Patient name _____ Date _____

Print Patient Name or Legal Guardian _____

HIPPA

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Name _____ **FLU VA** _____

DOB _____ **PVAX** _____

DRUG ALLERGIES AND INTOLERANCES

1. _____ **3.** _____

2. _____ **4.** _____

MEDICATION LIST

MEDICATION	DOSE	FREQUENCY

Primary Care Physician _____ Phone _____

Pharmacy _____ Location _____ Phone _____

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AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR MEDICARE PATIENTS

PATIENTS NAME _____ MEDICARE # _____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to ***Montgomery Pulmonary and Sleep Consultants P.C.*** for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable for related services."

I understand that information will be released to the billing department of the physician and/or practice.

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other health care professionals in order to coordinate my care or treatment
- Insurance adjuster if my claims is a work or motor vehicle injury
- Employer, if my claim is related to a work injury
- Attorney, if my claims are in a litigation process
- Health insurance carrier, for chart audit reason, and for claim payment

I understand that my physician and/or his staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that my physician and his/her staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information to be disclosed after it has been provided to others from the clinical billing office.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

Patient or Guardian Signature _____ Witness _____

Date _____ Date _____

A 2nd Signature is required for your Supplemental Insurance

I request that payment of authorized Medigap benefits be made either to me or on my behalf to my provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to my secondary insurer, named above, any information needed to determine these benefits payable for related services.

Signature of Patient or Guardian _____ Date _____

PATIENT AGREEMENT FOR FINANCIAL RESPONSIBILITY

I, _____, understand that the physician's billing staff will file all claims for services rendered to my insurance carrier, if applicable. I also understand that if I am not insured, I must pay my balance for services rendered by my provider. ***I acknowledge that I am responsible for any balances that may be due to the physician because of: co-insurance or co-pay amounts, yearly deductible amounts, non-covered services, out of network charges, terminated coverage, exhausted auto benefits, denied Worker's Compensation claim, no insurance coverage, no referral obtained from the Primary Physician, failure to respond to insurance carrier correspondence, failure to respond to coordination of benefits inquiry and cosmetic surgery.***

_____ _____

Signature of Patient/Guardian/Responsible Party Date (mm/dd/yy)