Pulmonary Physicians of Kansas City, Inc.

Timothy W. Smith, MD
Cosmo Caruso, MD
Patrick Perkins, MD
Samiran Patel, MD
Cheryl Daugherty, ANP-C

Patient Registration Form

Personal Information

Name ____ Date __________________

Birthdate _________________________ Soc. Security # _______ - _____ - _______

□ Male □ Female □ Single □ Married □ Divorced □ Widowed

Address ____

City, State, Zip ____

Employer _________________________________ Occupation __________________

Primary Care Physician ____________________________ Phone# ________________

Referred By ____

Contact Information

Home Phone _____________________________ Pharmacy Phone ________________

Work Phone _____________________________ Extension ____________________

Mobile Phone ___________________________ E-Mail ________________________

In the event of an emergency, who do you give us authorization to contact?

Name ______________________ Relationship _________ Contact # ______________

Insurance Information

Primary Insurance Information

Insurance Company ___________________

Name of Insured ______________________

Relationship to patient __________________

Insured's Birthday ______________________

Soc. Sec. # ________-______- ___________

Additional Insurance

Insurance Company ____________________

Name of Insured _______________________

Relationship to patient __________________

Insured's Birthday ______________________

Soc. Sec. # ________-______- ___________

(You must provide proof of insurance)

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Authorizations

Authorization for Release of Information

I, the undersigned, certify that I (or my dependant) have insurance coverage with ______________________________ and assign directly to Pulmonary Physicians of Kansas City, Inc., all insurance benefits payable to me for the services rendered by this group. **I understand that I am responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

Responsible Party Signature ___________________________ *Date*____ ________

Printed Name ____

Relationship to Patient ____

Financial Policy Acknowledgement

I have been given a copy of the financial policy for Pulmonary Physicians of Kansas City and understand that full payment of my office co-pay is due at the time of service. I understand that if I do not have insurance coverage, the full payment for services is due at the time the services are rendered unless payment arrangements have been made prior to my appointment.

*Patient/Guardian Signature*__________________________*Date*______________

We would like to thank you for taking the time to fill out this information sheet. Complete and accurate information is necessary for us to provide quality healthcare for you and your loved ones. Please return this information sheet to the front desk and be prepared to give you insurance card to the receptionist so we can have a copy on file for insurance claim submissions. Thank you again for your cooperation.

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Consent to Use and Disclose Protected Health Information

Use and Disclosure of your Protected Health Information

Your protected health information will be use by Pulmonary Physicians of Kansas City, Inc. (PPKC) and released to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting Restriction on the Use of Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

PPKC may or may not agree to restrict the use or disclosure of your protected health information. If PPKC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

PPKC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Pulmonary Physicians of Kansas City to use and disclose my health information in accordance with it.

____

(Name of Patient, Print or Type)

____ __________

(Signature of Patient) (Date)