ALTOONA LUNG SPECIALISTS

PATIENT FINANCIAL RESPONSIBILTY POLICY

Your signature below forms a binding agreement between ALTOONA LUNG SPECIALISTS (Medical Provider) and the Patient who is receiving medical services, or the Responsible Party for patients under the age of 18. The Responsible Party is the individual who is financially responsible for payment of all medical bills.

All charges for services rendered are due and payable at the time of service. We have contracts with most insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible for insuring that we participate in your insurance and for all payments due if your insurance company declines to pay for any reason.

The parties and/or the Responsible Party:

- MUST, at each office visit, inform Altoona Lung Specialists of the current address and telephone number of both the patient and the Responsible Party;
- MUST present all current insurance cards at each office visit;
- MUST verify, at each visit, the name of your family physician and all other necessary demographics;
- MUST comply with the Altoona Lung Specialists Payment Policy, as follows: **Effective immediately, we will require payment prior to any services being rendered, including any known co-pays, co-insurance(s), deductibles, and prior patient balances. We will require you to provide a credit card to secure payment for any unknown balance that your insurance carrier may not cover. Once Altoona Lung Specialists receives an Explanation of Benefits (EOB) from your insurance, and a statement is unpaid for thirty (30) days, we will charge your credit card for any outstanding balance that is owed.** Your signature will be required for authorization of payment.
- MUST agree to pay a $45 fee for checks returned for insufficient funds.

Failure to show up for an appointment will require a $100 deposit before the appointment can be rescheduled. This deposit will be refunded once the rescheduled visit is completed. Failure to attend the visit will result in the forfeiture of the $100 deposit.

All account balances must be paid in full. Should collection proceedings become necessary to collect balances on overdue accounts, the Patient will be terminated from the Practice.

As the Patient or the Responsible Party, your signature indicates that you have read, understand, and accept the terms and conditions in the Patient Financial Responsibility Policy.

Patient Printed Name	Responsible Party Printed Name
Patient Signature	Responsible Party Signature
Date	Date

LUNG DISEASE CENTER
OF CENTRAL PENNSYLVANIA
ALTOONA LUNG SPECIALISTS
800 CHESTNUT AVENUE
ALTOONA, PA 16601
PHONE: 814-946-2845 FAX: 814-946-1273

AUTHORIZATION FOR RELEASE OF INFORMATION

FOR PERSONS OTHER THAN YOURSELF OR YOUR PHYSICIAN

PATIENT NAME: _____ DOB: _____

I AUTHORIZE ALTOONA LUNG SPECIALISTS AND/OR MEMBERS OF ITS WORKFORCE TO RELEASE MEDICAL INFORMATION IN THE FORM OF TEST RESULTS, MEDICATION RENEWALS/REFILLS, APPOINTMENT DATES AND TIMES FOR DOCTORS TO WHOM I MAY BE REFERRED BY ALTOONA LUNG SPECIALISTS AND/OR OTHER NECESSARY MEDICAL INFORMATION:

1. _____
NAME OF INDIVIDUAL TO WHOM INFORMATION MAY BE RELEASED

_____
RELATIONSHIP TO PATIENT **PHONE**

2. _____
NAME OF INDIVIDUAL TO WHOM INFORMATION MAY BE RELEASED

_____
RELATIONSHIP TO PATIENT **PHONE**

3. _____
NAME OF INDIVIDUAL TO WHOM INFORMATION MAY BE RELEASED

_____
RELATIONSHIP TO PATIENT **PHONE**

☐ Patient Reviewed HIPAA Privacy Statement
☐ Privacy Alert

Appointment Information:
Home Phone (Include Auto Call)? ☐
Mobile Phone (Include Auto Call)? ☐
Mobile Text (Include Auto Call)? ☐
Work Phone? ☐
With Another Person? ☐
Send via Mail? ☐
Send via E-Mail? ☐
Patient Portal ☐
E-mail: _____
HIPAA Contact Instructions:

Medical Information:
Home Phone (Include Auto Call)? ☐
Mobile Phone (Include Auto Call)? ☐
Mobile Text (Include Auto Call)? ☐
Work Phone? ☐
With Another Person? ☐
Send Via Mail? ☐
Send Via E-Mail? ☐
Patient Portal ☐
Email: _____

THIS AUTHORIZATION IS VALID INDEFINITELY UNLESS OTHERWISE NOTED BY THE PATIENT

_____ _____
DATE PATIENT SIGNATURE

FOR PATIENTS WHO REFUSED TO SIGN AND DO NOT WANT INFORMATION RELEASED TO ANYONE

_____ _____ _____
OFFICE INITIAL DATE

CREDIT CARD AUTHORIZATION

PATIENT NAME: _____

CARDHOLDER NAME: _____

CARD NUMBER: _____

CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ DISCOVER

EXPIRATION DATE: _____ SECURITY CODE: _____

BILLING ZIP CODE: _____

☐ I hereby authorize Altoona Lung Specialists to charge the above credit card account if any account balance remains outstanding over thirty (30) days. I understand that I will be contacted prior to any credit card payments being processed.

☐ I decline placing my credit card information on file. I understand that by making this choice that at every appointment I must carry a ZERO BALANCE before being seen by the provider or to have any diagnostic testing. Also, I understand that if I am to have any testing done that would require me to take any equipment home, then I will need to provide my credit card information which will be kept on file temporarily until I return the equipment to the Altoona Lung Specialists.

_____ _____

Patient Signature Date

_____ _____

Cardholder Signature (if not patient) Date

THIS FORM MUST BE COMPLETED AND SIGNED PRIOR TO PATIENT BEING SEEN BY A PHYSICIAN!!