TEXAS LUNG CARE

PATIENT REGISTRATION FORM

Legal Last Name _____ Legal First Name _____ MI _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address (If different from home) _____

Preferred Phone Number (check one) ☐Home ☐Cell ☐Work _____

Alternate Phone Number (check one) ☐Home ☐Cell ☐Work _____

E-Mail Address _____ (for appt reminders & patient portal)

Employer _____ Address _____

Emergency Contact Name & Relationship _____ Phone _____

Pharmacy Name _____ Address _____

Referring Physician & Phone Number _____

Primary Care Physician & Phone Number _____

Does the patient have active health insurance coverage? ☐Yes ☐No

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

Is the patient the policyholder? ☐Yes ☐ No If No: Complete Responsible Party

Is the patient financially responsible for medical bills? ☐Yes ☐ No If No: Complete Responsible Party

Responsible Party Information (if different from patient)

Legal Last Name _____ Legal First Name _____ MI _____

Date of Birth _____ Social Security _____ Employer _____

Home Address _____ City _____ State _____ Zip _____

Preferred Phone _____

1643 Lancaster Drive #205 Grapevine, TX 76051
(T) 817-886-8552 (F) 877-958-2567
www.texaslungcare.com

TEXAS LUNG CARE

GENERAL CONSENT FORM

Consent for Treatment. I consent for Texas Lung Care Associates to administer treatments, tests, and/or diagnostic tests to treat my injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment received. **Patient Initials:** _____

Notice of Privacy Practices. I hereby acknowledge that I have received a copy of Texas Lung Care Associates Notice of Privacy Practices upon my request and have reviewed how my medical information will be used and disclosed. **Patient Initials:** _____

Prescription and Medical History Consent. I give Texas Lung Care Associates full permission to access my prescription medication history and access to my medical records regarding current/past medical conditions. **Patient Initials:** _____

Medical Records Policy. To obtain medical records, complete, sign, and submit the Authorization for Release of Patient Information form to our office by mail or in person. Fees may apply. **Patient Initials:** _____

Prescription Medication Policy. It is your responsibility to notify your pharmacy when refills are necessary. The pharmacy will contact our office with the request. **Approval of your refill can take up to three business days; please do not wait until you are out of medication! Medication refills will only be addressed during regular office hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.**

Patient Initials: _____

Involvement of Others in Care. I authorize Texas Lung Care Associates to discuss my care, not limited to medical needs, treatment, and payment options with the following persons:

Name	Relationship	Phone Number

May we contact by phone and leave a message about your care? On occasions when our office is unable to contact you, our staff may wish to leave you messages with personal health information. Please check the box below to indicate how you wish to receive messages:

- ☐ Leave message with detailed information (i.e. appointment reminders, etc.)
- ☐ Leave message with medical office call back information only
- ☐ Do not leave message (a follow up appointment will be required for communication)

Patient Name (print) _____ Date of Birth _____

Signature of Patient/Representative _____ Date _____

Printed Name of Patient's Representative (if applicable) _____

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PATIENT FINANCIAL POLICY

We are committed to providing you with quality care, and your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities as our patient. It is your responsibility to contact our office to notify us of any changes to your information, such as a change in address, telephone number, or insurance information.

You must complete and sign our Patient Financial Policy before care is rendered.

- Payment is due at the time of services, including copayments, deductibles, and coinsurance as applicable. If you are uninsured or if you are not insured by a plan we do business with, payment in full is expected at time of services.
- If you are insured, you must **bring your insurance information and a photo ID to every appointment** to ensure correct processing of all insurance claims. If you do not have your up-to-date insurance card, payment in full is required at the time of services if we cannot verify your coverage. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- We file insurance claims as a courtesy to our patients. Your insurance company may need you to provide certain information directly to the insurance company. You are responsible for complying with their request.
- There is a $50 fee for all returned checks.
- If you do not show up for an appointment or cancel with less than 24 hours' notice, you will be charged $50. You must pay this fee before you can schedule a new appointment. Patients with three missed appointments may be terminated from the practice.
- If your insurance company denies payment because of benefit limitations or noncovered services, you will be responsible for the charges.

Nonpayment. Please be aware that if a balance remains unpaid without partial payments, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Financial Hardship & Payment Plan. If other arrangements need to be made, please speak with the receptionist prior to your visit.

Assignment of Benefits. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans. I authorize any insurance company to pay benefits due directly to Texas Lung Care Associates and to release to my insurance carrier any medical records or documents requested to secure payment. This assignment will remain in effect until revoked by me in writing.

Medicare Release & Assignment of Benefits. I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this request for payment of medical insurance benefits either to myself or the party who accepts assignment.

I understand the Patient Financial Policy of Texas Lung Care Associates and I agree to be bound by its terms. I agree that I am financially responsible for all charges.

Patient Name (print) _____ Date of Birth _____

Signature of Patient/Representative _____ Date _____

Printed Name of Patient's Representative (if applicable) _____

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