PATIENT NAME: _____
FIRST *MIDDLE* *LAST* *MAIDEN*

SEX: M / F (circle) **BIRTHDATE**: _____ **AGE**: _____ **SOCIAL SECURITY NO**: _____

RACE: WHITE_____ BLACK / AFRICAN AMERICAN_____ MORE THAN ONE RACE_____ REFUSED TO REPORT _____

AMERICAN INDIAN/ALASKA NATIVE _____ NATIVE HAWAIIAN_____ OTHER PACIFIC ISLANDER_____ ASIAN_____

PREFERRED LANGUAGE: ENGLISH____ SPANISH____ JAPANESE____ GERMAN____ HINDI____ GREEK____ OTHER

ETHNICITY: NOT HISPANIC OR LATINO_____ HISPANIC OR LATINO _____ REFUSED TO REPORT/UNREPORTED_____

ADDRESS: _____**CITY**:_____**STATE:**_____**ZIP**:_____

TELEPHONE: HOME: _____ **WORK:** _____ **CELL:** _____

EMAIL:_____

EMPLOYED BY:_____ **PHONE:**_____

SPOUSE'S NAME:_____ **SPOUSE'S SS#:**_____

SPOUSE'S DOB:_____**PHONE:**_____

REFERRING PHYSICIAN:_____ **PHONE:**_____
NAME

PRIMARY CARE PHYSICIAN:_____ **PHONE:**_____
NAME

PHARMACY INFORMATION:_____ **PHONE:**_____
NAME

DURABLE MEDICAL EQUIPMENT COMPANY CURRENTLY USED

(CPAP, OXYGEN, NEBULIZERS OR OTHER EQUIPMENT/SUPPLIES)_____

EMERGENCY CONTACT INFORMATION

NAME:_____ **PHONE**:_____
SOMEONE NOT AT SAME ADDRESS AS YOU

INSURANCE AUTHORIZATION & RELEASE OF INFORMATION

I HEREBY AUTHORIZE AND REQUEST MY INSURANCE COMPANY, INCLUDING MEDICARE/CHAMPUS, TO PAY SALEM CHEST SPECIALISTS THE AMOUNT DUE ON MY CLAIM FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I FURTHER AGREE THAT SHOULD THE AMOUNT BE INSUFFICIENT TO COVER THE ENTIRE MEDICAL EXPENSE, I WILL BE RESPONSIBLE FOR PAYMENT OF THE DIFFERENCE. IF THE NATURE OF THE DISABILITY BE SUCH THAT IT IS NOT COVERED BY THE POLICY, I WILL BE RESPONSIBLE TO SALEM CHEST SPECIALISTS FOR PAYMENT OF THE ENTIRE BILL. I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENTS OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE COMPLETE AND ACCURATE INSURANCE INFORMATION, INCLUDING ANY UPDATES OR CHANGES IN COVERAGE. SHOULD I FAIL TO PROVIDE THIS INFORMATION AND INSURANCE IS FILED INCORRECTLY AS A RESULT, I UNDERSTAND THAT I WILL BE FINANCIALLY RESPONSIBLE.**

I UNDERSTAND IT IS THE POLICY OF SALEM CHEST SPECIALISTS THAT PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED INCLUDING HMOs, PPOs, MEDICARE AND MEDICAID CO-PAYMENTS AND/OR DEDUCTIBLES. EXCEPTIONS TO THIS POLICY MUST BE ARRANGED IN ADVANCE WITH THE PATIENT'S ACCOUNT MANAGER. ACCOUNT BALANCES OVER NINETY (90) DAYS ON WHICH NO PAYMENT HAS BEEN MADE MAY BE SUBJECT TO COLLECTION ACTIVITY.

I UNDERSTAND THAT SALEM CHEST SPECIALISTS RESERVES THE RIGHT TO CHARGE A FEE FOR NOT SHOWING UP FOR APPOINTMENTS.

SIGNATURE:_____**DATE:**_____