Med Record #:_____

Date _____ Referring Physician: _____

Primary Physician: _____

Personal Information

Patient Name: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Social Security #: _____ Date of Birth: _____ Sex M/F

Ethnicity_____ Race _____ Preferred Language_____

Martial Status (circle one) Married Single Divorced Widowed Separated

In what county do you live? _____ Do you smoke? _____

Employer Name _____ (Retired Y/N) Work Phone # _____

Employer Address _____

Spouse Name _____

Spouse SS# _____ Spouse Date of Birth_____

Spouse Employer _____ (Retired Y/N) Work Phone # _____

Spouse Employer Address _____

Emergency Contact _____ Phone # _____

Relationship_____

Insurance Information

Primary Insurance Company _____ Phone # _____

Claim Address_____

Policyholder Name _____ Relationship to you _____

Policy # _____ Group # _____

Policyholder Date of Birth _____ Policyholder Employer _____

Secondary Insurance Company _____ Phone # _____

Claim Address_____

Policyholder Name _____ Relationship to you _____

Policy # _____ Group #_____

Policyholder Date of Birth _____ Policyholder Employer _____

Is this a workers compensation claim? _____ if so, please complete a form for workers compensation.

Asheville Pulmonary & Critical Care Associates, P.A. files your insurance as a courtesy. You are ultimately responsible for your bill regardless of insurance benefits.

Medical Record #_____

CONSENT FOR TREATMENT

I hereby authorize Asheville Pulmonary & Critical Care Associates, P.A. to examine and treat me and to perform diagnostic tests and/or X-rays as may be necessary.

PERMISSION TO RELEASE INFORMATION

I authorize Asheville Pulmonary & Critical Care Associates, P.A. (APCCA) to release all medical information requested by my health insurance carrier, Medicare or any other third party payers. I authorize APCCA to release all medical information to my referring physician and my primary (family) physician. I authorize APCCA to contact Medicare, BCBS, Medicaid, or any other health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct Medicare, BCBS, Medicaid or any other health plan administrator to release such information to APCCA. I authorize access and release of confidential patient information by APCCA for purposes of photocopying the information in response to properly authorized requests for copies of patients' medical records.

If you anticipate the need for anyone else (spouse, family members, close friend, etc) to have access to this information please complete the information below:

Name _____ Relationship _____

_____ _____

_____ _____

Patient Signature: _____ Date: _____

This consent only allows the above persons / people to speak to APCCA personnel about the patients care / billing and records.

ACKNOWLEDGEMENT OF RECEIPT OF ASHEVILLE PULMONARY & CRITICAL CARE ASSOCIATES, P.A.'s NOTICE OF PRIVACY PRACTICES

I have received a copy of the Asheville Pulmonary & Critical Care Associates, P.A.'s Notice of Privacy Practices, which includes electronic access to medication history. I understand that Asheville Pulmonary & Critical Care Associates, P.A. has the right to change its Notice of Privacy Practices from time to time, and that I may contact Asheville Pulmonary & Critical Care Associates, P.A. at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____/_____/_____

Signature of Patient or Legal Representative Date

_____ _____/_____/_____

Print Name of Patient or Legal Representative Date of Birth

Medical Record #_____

Payment and No Show Policy

We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance** – We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Copayments, Co-Insurances, and Deductibles** – All co-payments, co-insurances, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays, co-insurances, and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments or deductibles at each visit.
3. **Non Covered Services** – Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare, Medicaid, or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of Insurance** – All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims Submission** – We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage Changes** – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment** – If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from the practice.
8. **Missed Appointments** – if you have missed three (3) consecutive appointments and have not contacted the office this would unfortunately prompt a dismissal from our practice. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____
Signature of Patient or Responsible Party Date