PEDIATRIC PULMONARY SPECIALISTS

David Rosenberg MD • John Prpich MD
4714 N. Armenia Avenue, Suite 201, Tampa, FL 33603

PATIENT INFORMATION

Please Complete Both Front and Back of Form

DATE _____ ACCOUNT # _____

How did you hear about our practice? _____

CHILD'S FULL NAME _____ _____ _____
First Middle Last Date of Birth Sex

Allergies? _____ Race _____

CHILD'S FULL NAME _____ _____ _____
First Middle Last Date of Birth Sex

Allergies? _____ Race _____

CHILD'S FULL NAME _____ _____ _____
First Middle Last Date of Birth Sex

Allergies? _____ Race _____

CHILD'S FULL NAME _____ _____ _____
First Middle Last Date of Birth Sex

Allergies? _____ Race _____

MOTHER / GUARDIAN:

Name _____
First MI Last

Birthdate____/____/____ SS#____/____/____

Occupation_____

Employer_____

Work / Daytime Phone (____) _____ Ext.____

Home Address_____

Apt #_____

City_____ State____ Zip____

Mailing Address_____

City_____ State____ Zip____

Home Phone (____) _____

Cell Phone (____) _____

Email_____

FATHER / GUARDIAN:

Name _____
First MI Last

Birthdate____/____/____ SS#____/____/____

Occupation_____

Employer_____

Work / Daytime Phone (____) _____ Ext.____

Home Address_____

Apt #_____

City_____ State____ Zip____

Mailing Address_____

City_____ State____ Zip____

Home Phone (____) _____

Cell Phone (____) _____

Email_____

If there are any family members or others who may be notified in an emergency or bring your child/children in for treatment and receive protected healthcare information (including HIV testing, drug and alcohol testing and psychotherapy treatment), please list below.

Name _____ Phone #_____ Relationship _____

Name _____ Phone #_____ Relationship _____

Name _____ Phone #_____ Relationship _____

PLEASE READ AND SIGN REVERSE SIDE

PEDIATRIC PULMONARY SPECIALISTS

David Rosenberg MD • John Prpich MD
4714 N. Armenia Avenue, Suite 201, Tampa, FL 33603

INSURANCE INFORMATION and FINANCIAL POLICY

POLICY HOLDER'S INFORMATION *Information MUST Be Completed To File Claims*

NAME _____ Birthdate____/____/____ SS#____/____/____
First Middle Last

Occupation_____ Employer_____

Employer's Address _____ City_____ State_____ Zip_____

ASSIGNMENT of INSURANCE

- ❑ I am self pay.
- ❑ I am self pay and file my own insurance.
- ❑ I authorize the release of medical information or other information necessary to process any claims for my dependants for payment.
- ❑ I authorize payment of benefits directly to the physician who accepts assignment and provided the services.
- ❑ I reside out of town and understand I will need to file my own claim and be reimbursed for payment.

SIGNATURE _____ DATE_____

FINANCIAL POLICY

1. All Fees are due at the time service is rendered. If not paid, there will be a $10.00 billing fee added to account.
2. Due to contractual obligations, no fees, co-pays or deductibles will be written off or forgiven.
3. Valid insurance cards must be presented at each office visit.
4. It is your responsibility to inform us of any changes to your insurance policy.
5. Not all services are a covered benefit will all insurance plans.
6. It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered medical benefit under your insurance policy.
7. You are responsible for any non-covered charges not payable by your insurance policy.
8. Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.
9. Please understand that each patient, or their parent or guardian, is responsible for payment of fees. If we participate in an insurance plan, we will file the claim for you. If we are not providers, payment in full is due at the time of service and submission of claim is the guarantor's responsibility.
10. All out of town patients are considered self-pay.
11. In the case of divorced or separated parents, responsibility shall be that of the parent or guardian bringing the child in for treatment.
12. Due to federal privacy regulations, the adult who brings the child in for treatment may be asked to present proof of identification at each visit (driver's license, etc.).
13. There will be a service charge on all returned checks. Normally, the bank presents an NSF check a second time automatically. Each rejection will result in an additional service charge to your account. After an NSF check, we require cash, credit card or money orders for payment.

This is the philosophy of the office. However, the office management reserves the right to amend this policy at any time.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account if you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO THE OFFICE POLICY.

_____ _____ _____ _____
GUARANTOR SIGNATURE DATE GUARANTOR SIGNATURE DATE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Pulmonary Specialist's may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Pulmonary's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Pulmonary Specialist's PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Pulmonary Specialist's Privacy Officer at 3003 W MLK Blvd, MAB 3rd Floor, Tampa, Fl 33607

With my consent, Pediatric Pulmonary Specialist's may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Pulmonary Specialist may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

PERMISSION FOR TREATMENT

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment by Pediatric Pulmonary Specialists deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with ( ) spouse ( ) other _____.

Please list the family members or others, if any, whom we may inform about your medical condition, in case of an emergency:

NAME: _____ PHONE # _____
NAME: _____ PHONE # _____

PRIVACY NOTICE

I have received a copy of Pediatric Pulmonary Specialist's privacy notice as required by HIPAA. By signing this form, I am consenting to Pediatric Pulmonary Specialist's use and disclosure of my PHI to carry out TPO. If I do not sign this consent, Pediatric Pulmonary Specialists may decline to provide treatment to me.

Signature: _____ **Date:** _____
Patient Name: _____ SS# _____
Relationship to Patient: _____
Witness: _____