Sleep-Wake Disorders Center of Havasu

PATIENT INFORMATION SHEET

Date: ______________

Patient Name: _________________________ DOB: __________Age: _____ Sex: M F Marital Status: M S D W

Email address: ____

Phone (____)_______-____________ 2nd Ph (____)_______-____________ SS # ________-______-________

1st Address:______________________________ City:_________________ ST: _____ZIP: ______________

2nd Address:______________________________ City:_________________ ST: _____ZIP: ______________

Referring Provider: ________________________________ Phone (____)_______-____________

Employer Name: __________________________________ Phone (____)_______-____________

Employer Address:________________________________ City:_______________________ ST: ____ ZIP: ________

Emergency Contact:__________________________ Relationship:___________ Phone (____)_______-____________

Insurance Information:

Primary Ins: ____________________________ Policy Holder:______________________ DOB:____/_____/_____

ID#: ________________________ Group#:______________________Policy Holder's DOB: _____/_____/______

Secondary Ins: __________________________Policy Holder:______________________ DOB:____/_____/_____

ID#: ________________________ Group#:______________________Policy Holder's DOB: _____/_____/______

I certify that the information contained in the Patient Information and Insurance form are true, complete, and correct, to the best of my knowledge.

Signature:_______________________________Date: _____/_____/______

Patient Name: ________________________ DOB: __________

To my Insurance Carriers: (Please initial)

1.________ I authorize the release of any medical information necessary to process my insurance claim(s).
2.________ I authorize and request payment of medical benefits directly to my provider.
3.________ I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4.________ I agree that a photocopy of this form may be used in lieu of the original.
5.________ I read and understand the Notice of Privacy Practice and that is available on-line.

Consent for use, Disclosure of Health Information and acknowledgment that our Notice of Privacy Practice is available at www.sleepresource.org:

Signature:_______________________________Date: _____/__/_____

I REVOKE my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

Signature:_______________________________Date: _____/__/_____

Regarding Insurance:

Your insurance policy is a contract between you and your insurance company. Please be sure to provide your current insurance cards, as we will need a copy of the front and back of your insurance card(s). As a courtesy, all services will be billed to your insurance company by our billing service. However, you are responsible for all co-pays and deductibles, as well as all non-covered charges and any payment mailed directly to you by your health insurance company. Questions or concerns regarding charges must be directed to our biller 928-248-5365.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.

Bad Debt / Collections:

If an account is turned over to a collection agency, all visits will be charged on a cash basis.