NEBRASKA PULMONARY SPECIALTIES, LLC

☐ NEW ☐ UPDATE

GENERAL PATIENT INFORMATION

(This information is necessary for our files and will be considered confidential) Date _____

(**Please check preferred contact number**)

1 ( ) _____ ☐ Home ☐ Work ☐ Cell

2 ( ) _____ ☐ Home ☐ Work ☐ Cell

PATIENT'S LAST NAME | FIRST NAME | MIDDLE

LOCAL ADDRESS | APT/LOT# | CITY | STATE | ZIP

PERMANENT ADDRESS (If Different than Local Address)

( ) _____ PHONE

EMAIL ADDRESS

SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | SEX: ☐ MALE ☐ FEMALE

PRIMARY CARE PHYSICIAN

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ LIFE PARTNER

PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____ REFERRED BY

ETHNICITY ☐ WHITE/CAUCASIAN ☐ HISPANIC/LATINO ☐ NON-HISPANIC ☐ AFRICAN AMERICAN ☐ ASIAN ☐ NATIVE AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ DECLINED

PHARMACY NAME & ADDRESS | PHARMACY NUMBER

SECONDARY/DME NAME & ADDRESS | SECONDARY/DME NUMBER

AUTHORIZED INDIVIDUAL

NAME | RELATIONSHIP | ( ) CONTACT NUMBER

☐ I UNDERSTAND THE ABOVE INDIVIDUAL IS AUTHORIZED TO RECEIVE INFORMATION REGARDING MY TREATMENT, CARE, AND ACCOUNT INFORMATION.

IN CASE OF EMERGENCY

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE | RELATIONSHIP | ( ) CONTACT NUMBER

☐ CHECK THIS BOX IF EMERGENCY CONTACT IS THE SAME AS YOUR AUTHORIZED INDIVIDUAL

IF THE PATIENT IS A MINOR OR STUDENT

IF PATIENT IS A MINOR, WHO MAY AUTHORIZE TREATMENT | RELATIONSHIP | D.O.B. | S.S.#

IF PATIENT IS A MINOR, WHO IS THE RESPONSIBLE PARTY | RELATIONSHIP | D.O.B. | S.S.#

( ) HOME PHONE | ( ) WORK PHONE | ( ) ALTERNATIVE PHONE

INSURANCE INFORMATION

INSURANCE COMPANY NAME | ( ) PHONE | IS THIS THROUGH EMPLOYER? ☐ YES ☐ NO

ADDRESS

EFFECTIVE DATE | GROUP NUMBER

INSURED'S NAME | INSURED'S SOCIAL SECURITY # | INSURED'S D.O.B. | INSURED'S I.D. NUMBER (Policy No.)

CO-PAY _____ SUBSCRIBER'S RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ _____

SECONDARY INSURANCE

SECONDARY INSURANCE COMPANY NAME | GROUP NUMBER | ( ) PHONE | IS THIS THROUGH EMPLOYER? ☐ YES ☐ NO

INSURED'S NAME | D.O.B. | INSURED'S I.D. NUMBER (Policy No.) | RELATIONSHIP TO PATIENT

IT IS YOUR RESPONSIBILITY TO PROVIDE YOUR INSURANCE COMPANY WITH ANY REQUESTED INFORMATION NEEDED TO PROCESS YOUR CLAIM. IF YOUR INSURANCE PLAN REQUIRES AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN IT IS **YOUR RESPONSIBILITY** TO HAVE THE AUTHORIZATION AT THE TIME OF YOUR VISIT. WITHOUT THE REQUIRED INFORMATION OR APPROPRIATE AUTHORIZATION, TODAY'S CHARGES MAY BE YOUR RESPONSIBILITY.

I AUTHORIZE THE DOCTOR TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER MEDICAL CARE. I AUTHORIZE AND REQUEST TO RELEASE MY MEDICAL RECORDS TO ANY OTHER PHYSICIAN/MEDICAL FACILITIES DIRECTLY INVOLVED IN MY CARE AND FOR THE PURPOSE OF ADMINISTERING CLAIMS. I HAVE BEEN MADE AWARE OF NEBRASKA PULMONARY SPECIALTIES NOTICE OF PRIVACY PRACTICES AND RECEIVE SERVICES OR SUPPLIES THAT ARE NOT COVERED BY MY INSURANCE PLAN AND I AGREE TO BE DIRECTLY RESPONSIBLE FOR THESE EXPENSES. I UNDERSTAND COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. DELINQUENT ACCOUNTS MAY BE REFERRED TO A COLLECTION AGENCY FOR PAYMENT. ASSOCIATED COLLECTION AGENCY COSTS WILL BE YOUR RESPONSIBILITY.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____