

New Patient Form

Alabama Sleep Clinic

Date _____

Patient Information

Patient's Name _____
Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ include area code Cell Phone _____ include area code

Sex _____ Birth Date _____ mm/dd/yyyy Age _____ SSN _____ Driver's Lic. # _____ Marital Status _____

Father's Name _____
Last Name First Name Middle Name Name goes by

Father's Employer _____ Occupation _____ Work Phone _____ include area code

Mother's Name _____
Last Name First Name Middle Name Name goes by

Mother's Employer _____ Occupation _____ Work Phone _____ include area code

Emergency Contact

Contact's Name _____ Relationship _____ Phone _____ include area code

Insurance Information

Insurance #1 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ mm/dd/yyyy SSN _____

Insurance #2 _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ mm/dd/yyyy SSN _____

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

I hereby authorize Alabama Sleep Clinic to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Alabama Sleep Clinic or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____

Alabama Sleep Clinic

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Pursuant to the requirements found in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following is offered for your information and consent. Please be aware that it is this office's policy to require your reading and signing this consent form prior to the provision of treatment or any other medical services. If you have any questions, please ask for the Privacy Official in this office.

I, _____, currently residing at _____ of (city) _____, (county) _____ (state) _____, do hereby consent to the use and disclosure of my individually identifiable health information ("Health information") by Alabama Sleep Clinic, PC for the purpose of providing treatment to me, receiving payment from responsible parties for health care services rendered by provider, and/or engaging in health care operations, such as office management, credentialing case management, and quality assessment.

I understand the Provider's Notice of Privacy Practice ("Notice") describes in more detail all types of uses of disclosures of Health Information involved in treatment, payment or health care operations, and that I have a right to review such Notice prior to signing this consent.

I understand that this Provider has reserved the right to change its privacy practices as described in the Notice. In the event of any change in the Provider's privacy practices, Provider will revise the Notice. I understand that I can obtain a copy of the revised Notice by writing to the Provider.

I understand that if I choose not to sign this consent, Provider may withhold medical services, other than emergency services.

I understand that if I choose not to sign this consent, Provider may withhold medical services other than emergency services.

I understand that I have the right to request a restriction of Provider's use or disclosure of any Health Information to any and/or all locations, entities or persons. I further understand that Provider is not obligated to agree to my request. However, if Provider does agree to my request, the agreement will become binding.

I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has relied on this consent, and that any revocation will become effective on the date it has been received by Provider and will apply to uses and disclosures of Health Information after the date of receipt.

Dated this _____ day of _____, 20__.

Patient signature: _____

PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

I understand that the Alabama Sleep Clinic has made available to me a copy of the Notice of Privacy Practices and will release my information for billing, diagnostic and treatment purposes only.

Patient Name: _____ Date of Birth: _____ SSN: _____
Please Print

Patient signature: _____

Alabama Sleep Clinic

TREATMENT COMPLIANCE AND SAFETY RECOMMENDATIONS

I acknowledge that I have read, understand and accept the following prior to undergoing my initial evaluation at the Alabama Sleep Clinic.

Certain sleep disorders can potentially lead to physical illness, injury or even death if untreated. The Sleep Clinic recommends that all patients be compliant with treatment, attend scheduled office visits, and reschedule missed or cancelled appointments.

Sleepiness can be dangerous and even life threatening. You should not drive when feeling sleepy and if you begin to feel sleepy while operating a motor vehicle you should safely stop driving until you no longer feel sleepy.

The purpose of this policy is to assist the Sleep Clinic in providing you with the best possible care. If you have any questions or concerns regarding this policy please feel free to discuss them with the office manager.

Name: (PRINT) _____

Signature: _____ Date: _____

CANCELLATION POLICY

Patients are responsible for canceling all scheduled appointments. Failure to keep an appointment without giving at least 48 hours notice will generate a charge of \$25.00 to the patient's account. The patient is responsible for this charge, which is non-billable to the insurance company.

Patient signature: _____ Date: _____

MEDICAL RECORD RELEASE

I, _____, hereby authorize Alabama Sleep Clinic to release information regarding my medical treatment and/or financial records to the following:

NAME

RELATIONSHIP TO PATIENT

Patient signature: _____ Date: _____

Witnessed by: _____ Date: _____
