SLEEP AND FAMILY MEDICINE

Patient Registration form

Patient's Name (Last, First, MI):_____

Patient's Primary Phone Number:_____ Alternate Phone Number (☐ cell or ☐ work):_____

E-Mail Address:_____ Do you prefer email or text?_____

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ Sex: ☐☐ Social Security Number:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐

Patient's Employer:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☑ Student ☐ Other: _____

Emergency Contact:_____ Relationship to Patient:_____

Address:_____ Phone Number:_____

INSURANCE INFORMATION

Primary Insurance:_____

Patient is Subscriber/Policy Holder: ☐☐

PAYMENT IS EXPECTED AT TIME OF SERVICE

Secondary Insurance:_____

Patient is Subscriber/Policy Holder: ☐☐

INSURED INFORMATION (IF OTHER THAN PATIENT) – We will request to scan your ID and insurance card

Subscriber/Policy Holder:_____ Relationship to Patient:_____

Address:_____

Social Security Number:_____

Date of Birth:_____

Employer:_____ Work Phone Number:_____

Sleep and Family Medicine reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: New Patient $20.00; Established Patient: $10.00

Patient/Parent or Guardian Signature:_____ Date:_____

Authorization for Claims Payment and Reviews

1. **Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all preferred physician organization, health maintenance organization, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Sleep and Family Medicine for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Sleep and Family Medicine for services rendered to me during the applicable periods of medical care.

2. **Unauthorized, Non-Covered, or Out of Plan Services** – I understand if my Insurance Plan(s) does not consider any service rendered a covered service, or has not authorized this service, they will not pay for the service rendered during this office visit. I agree to be fully responsible for payment to Sleep and Family Medicine for any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge in the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. **For Medicare Recipients Only** – I request that payment of authorized Medicare benefits be made on my behalf to the physicians at Sleep and Family Medicine for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

4. **Residents, Interns or Medical Students** – I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Sleep and Family Medicine's education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. *I understand and agree this document will remain in effect for all physician office visits to Sleep and Family Medicine, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

I certify that I have been made aware of Sleep and Family Medicine's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills. The Notice also describes my rights and Sleep and Family Medicine's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration area. Sleep and Family Medicine reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**.

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____

DATE

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE AUTHORITY

SLEEP & FAMILY MEDICINE
202 James Coleman Drive, Suite A
Victoria, TX 77904
361-573-4000

Medical Information Release Form

This authorizes Sleep & Family Medicine to provide a copy, summary, or narrative of my medical information or otherwise release confidential information to the following parties:

*Name:*_____ *Relationship:*_____

*Date of birth:*_____ *Phone#*_____

*Address:*_____

*City:*_____ *State:*_____ *Zip:*_____

*Name:*_____ *Relationship:*_____

*Date of birth:*_____ *Phone#*_____

*Address:*_____

*City:*_____ *State:*_____ *Zip:*_____

*Name:*_____ *Relationship:*_____

*Date of birth:*_____ *Phone#*_____

*Address:*_____

*City:*_____ *State:*_____ *Zip:*_____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies, or infection with any other causative agent of AIDS, with the rest of my medical records.

Patient/Representative Signature:_____ Date:_____

Patient Name (Print):_____ Date of Birth:_____