SANTA BARBARA PULMONARY ASSOCIATES

PATIENT REGISTRATION

Please PRINT

NAME: _____

LAST FIRST MIDDLE INITIAL

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

STREET ADDRESS: _____

HOME PHONE: (_____)_____ **GENDER**: (Circle one) MALE FEMALE

CELL PHONE: (_____)_____ **BIRTHDATE**: _____ / _____ / _____

SOCIAL SECURITY #: _____-_____-_____ **EMAIL ADDRESS**: _____

MARITAL STATUS:(Circle one) S M W D **RACE**:(Circle) White Asian Black or African American American Indian Native Hawaiian Hispanic

SPOUSE'S NAME: _____ **SPOUSE'S PHONE**: (_____)_____

EMERGENCY CONTACT: _____ **PHONE:** (_____)_____

Different than your phone #

Relationship to patient: _____

RESPONSIBLE PARTY: (Circle one) SELF PARENT/GUARDIAN: _____ OTHER:_____

INSURANCE INFORMATION:

PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

Financial Policy: I hereby authorize treatment by Drs. Wright, Belkin, and Sager and understand that I am financially responsible for all fees and charges for such treatment whether or not they are covered by my insurance policy. I understand Drs. Wright, Belkin, and Sager are contracted with some, not all, insurance plans and it is my responsibility to be aware of the terms and limitations of my insurance coverage. If my insurance policy is through an HMO I understand that it is my responsibility to ensure that authorization has been obtained from my primary care physician **prior** to receiving services from Drs. Wright, Belkin, and Sager. If such authorization has not been given, I understand that I will be financially responsible for all fees and charges.

I understand that during the course of my office visit with Drs. Wright, Belkin, and Sager it may be necessary for him to perform additional diagnostic or therapeutic services at his discretion. I understand that charges for these services will be in addition to the regular office charges.

I authorize Drs. Wright, Belkin, and Sager to furnish any medical information necessary to prove my claim to my insurance carrier and to other physicians, hospitals, and health care facilities and hereby irrevocably assign to the doctor payment for all medical services and unpaid balances. I authorize copies of this authorization to be used in place of the original. If my account is referred to an attorney or collection agency, I agree to pay reasonable fees and collection expenses.

Cancellation Policy: Office visits not cancelled with 24 hour notice are subject to a fee of $75.00

This authorization will remain in effect until revoked by me in writing.

SIGNATURE: _____ DATE: _____