PULMONARY ASSOCIATES
DONALD HO, M.D.
BERNARD J. STEYER, M.D.
LAWRENCE A. COSKEY, M.D.
ROBERT M. JASMER, M.D.
CHARLES K. EVERETT, M.D.

PENINSULA SLEEP CENTER, INC.
MEHRAN FARID-MOAYER, M.D., FAASM
DEEPTI SINHA, M.D., FRACP

[ ]PULMONARY CONSULTATION
[ ]SLEEP MEDICINE CONSULTATION

Patient Name _____
Last Name First Name Middle Initial

Birthdate ___/___/___ Age _____ Sex Male / Female
Mo Day Year

Address _____ Apt.# _____ City _____

State _____ Zip _____ Social Security # _____

Home Phone (___) _____ Cell Phone (___) _____ Marital Status S( ) M ( ) W ( ) D ( )

Email _____

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone (___) _____

Spouse's Name _____ Spouse's Birthdate ___/___/___
Mo Day Year

Spouse Employed By _____ Business Phone (___) _____

Emergency Contact _____ Phone (___) _____

Preferred Pharmacy _____ City _____

Primary Physician _____ Which Dr. will you see today? _____

* Ethnicity ( ) Hispanic or Latino ( ) Not Hispanic or Latino

* Race ( ) American Indian or Alaska Native ( )Asian ( ) Black or African American

( ) Hispanic or Latino ( ) Multiracial ( ) Native America ( ) Native Hawaiian or other Pacific Islander

( ) Other ( ) White

*Preferred Language _____

* The US Government is mandating that the information is collected from our patients.

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RELEASE OF INFORMATION / FINANCIAL AGREEMENT / PRIVACY POLICY

- *I authorize Pulmonary Associates or Peninsula Sleep Center physicians to release all information necessary to secure the payment of benefits. I understand claims are submitted electronically.*
- *I hereby give authorization for payment of insurance benefits, otherwise payable to me, to be made directly to Pulmonary Associates or Peninsula Sleep Center physicians for professional services rendered.*
- *I understand that I am financially responsible for all charges, co-pays, co-insurance amounts (whether or not they are covered by my insurance), administrative charges, prescription drug pre-authorizations, special reports, letters, and fees to process forms.*
- *I understand that it is my responsibility to verify that Pulmonary Associates or Peninsula Sleep Center physicians are providers of my insurance company and to pay any collection recovery fees for delinquent balances.*
- *A photocopy of this agreement shall be as valid as the original.*
- *I have received copy of the HIPAA notice of Privacy Policies and Practices.*
- *For appointment cancellation: I understand I am financially responsible for a cancellation fee for an unkept appointment or for failure to provide cancellation notice of at least 24 hours.*

Signature _____ Date _____