HOWARD COUNTY CENTER for LUNG AND SLEEP MEDICINE

PATIENT REGISTRATION FORM

Last Name _____ First Name _____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

Date of Birth_____ Age _____ SS# _____ ☐ Male ☐ Female

Preferred Phone # (home/cell/work) _____ Other Phone # (home/cell/work) _____

E-Mail Address _____ (for appointment reminders and office contact)

Race_____ Ethnicity _____ Preferred language _____

Employer _____ Address _____

Spouse or Parent's Name_____ Phone # (home/cell/work) _____

Address _____ City_____ State _____ Zip _____

Emergency Contact Name _____ Phone # _____

Referring Doctor _____ Phone # _____

Pharmacy Name* _____ Pharm. Address _____

Primary Insurance Company _____ Policy # _____ Group # _____

If not self: Policyholder _____ Relationship to Patient _____

Address _____

Date of Birth _____ SS# _____ Employer _____

Secondary Insurance Company _____ _____ Policy # _____ Group # _____

If not self: Policyholder _____ Relationship to Patient _____

Address _____

Date of Birth _____ SS# _____ Employer _____

On occasions when our office is unable to contact you, our staff may wish to leave you messages with personal health information. Healthcare information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/ lab results, prescription/ pharmacy information, appointment reminders, and instructions for appointments for office visits and procedures.

_____ (Initial) **YES,** I agree to allow Howard County Center for Lung & Sleep Medicine, LLC to leave messages and/or send letters that include Protected Healthcare Information on the following: (*Circle the allowed means of communication*)

Telephone: Home / Cell / Work E-Mail Home address

_____ (Initial) **NO**, I do not agree to allow Howard County Center for Lung & Sleep Medicine, LLC. to leave messages that include Protected Healthcare Information. If checking "NO" to this statement, a follow up appointment must be made to obtain your Protected Healthcare Information.

Please refer to the "Patient Policy" documents that contain our office policies, for which you have read and acknowledge:

☐ I have read and understand the **Patient Financial Responsibility Policy** of Howard County Center for Lung and Sleep Medicine, LLC (HCCLSM) and I agree to be bound by its terms. I agree to pay any finance charges incurred by failure to pay the balance due on my account in full within ninety (90) days of the bill date.

☐ I hereby assign any and all insurance benefits due and payable to me by any insurance policy to Howard County Center for Lung and Sleep Medicine, LLC for services rendered. I authorize any insurance company to pay benefits due directly to HCCLSM to release to my insurance carrier any medical records or other documents requested by the carrier which are deemed necessary by the carrier to process payments of the claim.

☐ I understand that I am financially responsible to pay HCCLSM for any and all fees incurred by the practice in collecting all outstanding debts sent to the collection agency or lawyer.

☐ I have read and understand Howard County Center for Lung and Sleep Medicine, LLC 's **Appointment Scheduling Policy** and I agree to be bound by its terms. I have received a copy of my signed policy. I also understand that such terms may be amended periodically by the practice with notice.

☐ I hereby acknowledge that I have received a copy of Howard County Center for Lung and Sleep Medicine, LLC's **Notice of Privacy Practices** upon my request. I understand that my health information and records are confidential and will not be used or disclosed without my written authorization. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

☐ I understand and have received a copy of the **Medication Refills and Medical Records policies.**

_____ _____

Patient Name **Date**

_____ _____

Signature of Patient or Legal Representative **Guarantor's Signature**

_____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

☐ Parent or guardian of un-emancipated minor

☐ Court appointed guardian

☐ Executor or administrator of decedent's estate

☐ Power of Attorney

_____

Witness

ADVANCE DIRECTIVES STATEMENT

This statement is provided by Howard County Center for Lung and Sleep Medicine, LLC, in accordance with a federal law called the Patient Self-Determination Act of 1990. This law requires that Howard County Center for Lung and Sleep Medicine, LLC, provide each patient with written information concerning our policies for implementing a patient's rights to make health care decisions and to formulate advance directives.

Howard County Center for Lung and Sleep Medicine, LLC respects the right of each adult to participate in health care decision-making to the maximum extent of his or her ability, and respects the right consistent with the requirements of the laws of Maryland. To this end, Howard County Center for Lung and Sleep Medicine, LLC has instituted specific policies and procedures to ensure that a patient's wishes with respect to his or her individual health care decisions are respected.

To ensure your ability to participate in your care, the Howard County Center for Lung and Sleep Medicine, LLC policy requires that we:

1. Comply with the applicable Maryland laws**,** including statutes and court decisions regarding your right to make health care decisions and to formulate advance directives.

2. Provide you with written information to inform you that you have the right under Maryland law to accept or refuse medical or surgical care or treatment and to formulate advance directives.

3. Document in your medical record whether you have executed an advance directive.

4. Make you aware that Howard County Center for Lung and Sleep Medicine, LLC shall not condition the provision of your care or otherwise discriminate against you in any way based upon whether or not you have executed an advance directive.

Separate forms for both a durable power of attorney for health care decisions and a living will that are recognized as valid under Maryland law are available. If you wish to obtain copies of these forms you may contact:

Library and Information Services Division
Department of Legislative Reference
90 State Circle
Annapolis, MD 21401
Baltimore/Annapolis: 410-841-3810/3886
Washington, DC: 301-858-3810/3886
All other areas: 1-800-492-7122, ext. 3810/3886

This form has been discussed with me and received by me. I have also received an information packet explaining advance directives.

_____ At present, I do not have an Advance Directive.

_____ At present, I do have an Advance Directive, and I will forward a copy to Howard County Center for Lung and Sleep Medicine, LLC to be placed with my record.

_____

Patient Signature Date

_____

Responsible Party Relationship Date