FOOTHILL PULMONARY AND CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

Patient Personal Information

Name: _____

Address: _____

City/ST/Zip: _____

Social Security Number: _____

Date of Birth: ____/____/____ Circle Gender: Female Male

Phone (Home) (____) _____

Phone (Work) (____) _____

Phone (Cell) (____) _____

Occupation / Student: _____

Employer / School: _____

Referred by: _____

Responsible Party Information

Name: _____

Address: _____

City/ST/Zip: _____

Date of Birth: ____/____/____

Social Security Number: _____

Phone (Circle Home/ Work/ Cell) (____) _____

Relationship to Patient: _____

Emergency Contact

Name: _____

Phone(Home/ Work/ Cell) _____

Phone(Home/ Work/ Cell) _____

Insurance Information

Insurance carrier: _____

Insurance I.D. #: _____

Type (circle one) HMO PPO POS Medicare Medi-Cal

Secondary Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Spouse Information

Name: _____

Address: _____

City /ST/ Zip: _____

Date of Birth: _____

Phone (Circle Home/Work/Cell): (____) _____

Relationship to Patient: _____

Pharmacy: _____

Authorization

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up lab information, prescriptions, other referral information from Foothill Pulmonary and Critical Care Consultants Medical Group, Inc., and to make and receive phone calls regarding my health and or the billing related to the service provided to me by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc.

☐ SPOUSE: _____ ☐ CAREGIVER: _____

☐ CHILDREN: _____

☐ OTHER: _____

ASSIGNMENTS OF BENEFITS

I hereby assign payment of authorized Medicare and any other medical and/ or surgical benefits, to include major medical benefits to which I am entitled, to be made either for me or on my behalf to Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. for any services furnished to me by the physician/ supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. "I certify that I am eligible for benefits under the pre-paid health benefit plan. In the event I am later found to be ineligible, or as consideration for being treated without proof of eligibility, I agree to pay for any and all services provided by Foothill Pulmonary and Critical Care Consultants Medical Group Inc. at their fees then in effect."

SIGNATURE: _____ **DATE:** _____

HIPPA PRIVACY POLICY

Our notice of Privacy Practices advises how we may use and disclose protected health information about you. Our current notice is available in our lobby, or upon request. I agree to the uses and disclosure of my information for purposes of treatment, payment and practice operations.

SIGNATURE: _____ **DATE** _____