PULMONARY AND CRITICAL CARE SPECIALISTS of NORTHERN VIRGINIA, P.C.

REFERRED BY: _____ **PRIMARY PHYSICIAN:** _____
Referring Physician Family Physician

PATIENT NAME _____ **DATE OF BIRTH** ____/____/_____ **AGE** _____

SS # _____/_____/_____ ☐ **Male** ☐ **Female** **MARITAL STATUS** _____ *** CELL #** _____

ADDRESS _____ **HOME #** _____

_____ **WORK #** _____

EMAIL: _____@_____ **EMERGENCY CONTACT #** _____

PATIENT OCCUPATION _____ ☐ **FT** ☐ **PT** ☐ **STUDENT** ☐ **RETIRED**

NAME OF EMPLOYER OR SCHOOL _____

EMPLOYER OR SCHOOL ADDRESS _____

SPOUSE OR NEXT OF KIN _____ **RELATIONSHIP TO PATIENT** _____

ADDRESS _____ **PHONE #** _____

Invitation to Race/Ethnicity: ☐ (Caucasian) ☐ (Asian or Pac. Islander) ☐ (African American) ☐ (Hispanic) ☐ (Native Amer. or Alaskan Native) or ☐ Declined (please initial) _____

PRIMARY INSURANCE _____ **REFERRAL/AUTH –** ☐ **Yes** ☐ **No**

ADDRESS _____ **PHONE #** _____

_____ **GROUP #** _____

ID # OR MEMBERSHIP # _____ **SS #** _____/_____/_____

NAME OF POLICYHOLDER _____ **DATE OF BIRTH** _____

POLICYHOLDER IS: ☐ **SELF** ☐ **SPOUSE** ☐ **OTHER**___ **POLICYHOLDER EMPLOYER:** _____

SECONDARY INSURANCE _____ **REFERRAL/AUTH –** ☐ **Yes** ☐ **No**

ADDRESS _____ **PHONE #** _____

_____ **GROUP #** _____

ID # OR MEMBERSHIP # _____ **SS #** _____/_____/_____

NAME OF POLICYHOLDER _____ **DATE OF BIRTH** _____

POLICYHOLDER IS: ☐ **SELF** ☐ **SPOUSE** ☐ **OTHER**___ **POLICYHOLDER EMPLOYER:** _____

I, the undersigned, understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Pulmonary & Critical Care Specialists to release all necessary information necessary to facilitate the processing of all claims related to my care; my authorization allows insurance claim(s) submissions on my behalf.

I hereby acknowledge Pulmonary & Critical Care Specialists "Notice of Privacy" for protected health information and acknowledge Pulmonary & Critical Care Specialists may use or disclose personal health information relating to me for purposes of treatment, payment, and health operation as disclosed in the Notice of Privacy.

I acknowledge that Pulmonary & Critical Care Specialists reserves the right to charge a fee for missed appointments or procedures. A missed appointment is defined as failure to show for your scheduled appointment or cancellation for appointment or procedure within less than 24 hours of scheduled time.

PATIENT SIGNATURE: _____ **DATE:** _____
(Or authorized financially responsible party)

NOTE: Please print and bring to your appointment.