CAPITAL PULMONARY INTERNISTS, PC
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DR. BYRON S. COOPER DR. DAVID C. GROSS DR. GARY H. MILLER DR. BRIAN C. TURRISI, M.D.

WELCOME TO OUR OFFICE

PATIENT NAME ______________________________________ SSN# ________-______-________

ADDRESS ____ BIRTHDATE _____/_____/______

CITY _____________________________________ STATE __________ ZIP CODE ______________

HOME PHONE (_____)_____________________ WORK PHONE (_____)____________________

CELL PHONE (_____)_____________________

MALE___ FEMALE___ MARITAL STATUS ___S____M EMPLOYER__________________________

REFERRED BY _____________________________ EMPLOYER ADDRESS _____________________

PRIMARY INSURANCE __________________________________ EFF.DATE ______/_____/_______

POLICY #____ GROUP # ____________________

SECONDARY INSURANCE ______________________________ EFF.DATE ______/_____/_______

POLICY # ____ GROUP # ____________________

POLICY HOLDER NAME (If different from patient) ______________________________________

POLICY HOLDER BIRTHDATE _____________POLICY HOLDER SSN# ______-_____-________

IF YOUR VISIT IS FOR SPECIALIST CARE ONLY, WHO IS YOUR PRIMARY PHYSICIAN?

NAME ____ PHONE # _________________________

EMERGENCY CONTACT: NAME____

PHONE#____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BILLING OFFICE. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS, AS INDICATED ABOVE, BE MADE ON MY BEHALF TO CAPITAL PULMONARY INTERNISTS, P.C. FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIER OR ANY OTHER INSURANCE COMPANY ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/OTHER INSURANCE CO. CLAIM. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF ITEM 9 OF THE HCFA-1500 CLAIM FORM IS COMPLETED, MY SIGNATURE AUTHORIZES THE RELEASE OF INFORMATION TO THE INSURER SHOWN. IN MEDICARE/OTHER INSURANCE COMPANY ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF MEDICARE/OTHER INSURANCE COMPANY AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE,COINSURANCE, & UNCOVERED SERVICES. COINSURANCE AND DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF MEDICARE/OTHER INSURANCE. CO.

SIGNATURE ____ DATE__________________