Sleep Medicine Institute of Texas, PA

Patient Name: ____________________________

Date of Birth: _________________

PATIENT REGISTRATION FORM

Patient Last Name: ___________________________________First Name: _____________________Date:______________

Address ____City__________________State________Zip____________

Date of birth___________________ Gender _______Social Security #___________________Marital Status: __________

Home phone _____________________________Cell Phone ______________________Preferred Phone: **Home** **Cell**

Email address (required) ____

Primary care doctor Name____City__________State_____________

Referring doctor Name____City__________State_____________

Employer Name **____City__________State_____________**

Emergency contact name ____Date of birth____________________

Emergency contact phone____Relationship____________________

Ethnicity	Language	Race	
Hispanic/Latino	English	American Indian	Caucasian
Not Hispanic/Latino	Spanish	Asian	Hawaiian
Prefer not to answer	Other:	African-American	Unknown

How did you find us? Internet Facebook Website Doctor family/friend Radio TV Billboard

Primary insurance Carrier

Company name_________________________________ID:______________________Group#____________________

Subscriber Name ________________________________Birthdate__________________Relationship_________________

Secondary Insurance Carrier

Company name_________________________________ID:_____________________Group#_________________

Subscriber Name _______________________________Birthdate __________________Relationship_____________

I voluntarily consent to medical treatment at Sleep Medicine Institute of Texas. I authorize the holder of medical or other information to release to my insurance carrier any information needed for this or related insurance claim. I agree to pay any charges incurred by me to Sleep Medicine Institute of Texas.

____ **_______________**

Patient Signature/Guardian if patient is minor **Date**

A VALID PHOTO ID AND INSURANCE CARD(S) ARE REQUIRED AT CHECK IN

Patient Name: ___________________________

Date of Birth: ________________

FINANCIAL POLICIES: PLEAES READ THE ENTIRE DOCUMENT. The policies outlined below are established to avoid any misunderstandings and to allow for a proper understanding of patient responsibilities.

- It is patient's responsibility to provide Sleep Medicine Institute of Texas with your current health insurance, your primary and secondary health insurance and any change or termination of your health insurance coverage and demographic information and to bring your insurance card(s) at each visit.
- If you have **Medicaid** coverage of any kind you must inform us of the same prior to your visit. This is part of your agreement with Medicaid and failure to notify us of **Medicaid** coverage will result in full responsibility for services rendered. **Sleep Medicine Institute of Texas is not contracted with Medicaid.**
- It is the patient's responsibility to pay any copay, deductible or co-insurance at the time of visit. Certain services such as sleep studies, oral appliances and PAP machines require pre-service payments.
- Any medical service not covered by the patient's insurance plan are the patient's responsibility and payment in full is due at the time of service.
- It is the patient's responsibility to ensure that proper referrals are provided to our office as needed by the patient's insurance company. If a valid and current referral from your primary care physician is not on file at the time of visit the appointment will be rescheduled or the patient may be responsible for the charges due to lack of referral.
- The patient or guarantor on the account will be billed for any patient due balances after patient's health insurance has paid. Upon request an itemized statement will be provided in 10 business days.
- If there is an overpayment on the patient's account a refund will be issued to the patient in the same method that the payment was made.
- For a patient who is a minor, the adult responsible for payment will be required to make the payments at /before the time of the visit. If the parents are divorced then the financial responsibility lies with the parent who seeks the treatment for. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of Sleep Medicine Institute of Texas.
- Returned checks: There will be a $25 service charge for checks returned for insufficient funds.
- Payments can be made with all major credit cards, checks and cash.
- Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

I understand the above information and agree to be responsible for the patient below:

Signature of patient /responsible party ________________________________Date_____________

Patient Name: ____________________________

Date of Birth: _________________

GENERAL POLICIES

The following information about our practice will give you a better understanding of the various procedures within out practice. If you have any questions please do not hesitate to ask our staff. Thank you!

- **Appointments:** At each appointment you will be asked to confirm your demographic and insurance information. Please arrive prior to your appointment time with your photo ID and insurance card(s). Patients arriving more than 15 mins late or New patients arriving without a valid photo ID may have to be rescheduled.
- **Appointment cancellations / No-shows:** We understand unexpected things happen. Appointments are in high demand and it is very important that you keep your appointment time. If you are unable to keep your appointment, please call our office and let us know 24 hours in advance so that we may open that slot for another patient. Without prior advance notice to the office you will be charged a $25 fee for clinic visits, $100 for missed Sleep studies and sleep studies cancelled before 12 noon the previous business day. For Durable Medical Equipment supplies, there is a $40 re-stocking fee if the supplies are not picked up within 5 business days.
- **Assignment of benefits:** I do hereby assign payment directly to Sleep Medicine Institute of Texas for medical benefits for professional services rendered. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize the release of information as may be necessary for purpose of treatment, payment and operations such as credentialing, peer review, accreditation and compliance with state and federal laws.
- **Insurance referrals to see a specialist:** It is your responsibility to make sure that Dr. R. V. Ghuge and Sleep Medicine Institute of Texas is in your insurance network before making an appointment. If your health insurance requires a referral, it is your responsibility to obtain a referral prior to any service at Sleep Medicine Institute of Texas. Failure to obtain a referral will cause your insurance benefits being paid at a reduced rate or not paid at all. You, the patient, would then be responsible for the amount not paid by insurance.
- **Prescription Refills:** Please do not wait till you run out of medication to get a refill. Contact your pharmacy for all prescription refills 72 hours in advance of needing a refill. Please be aware no refill requests will be completed after hours, on holidays or over the weekend. Certain controlled substances will only be refilled during regular business hours. Please allow two business days to process a medication refill.
- **Pre-authorizations for medications, sleep studies and other procedures**:
  If your health insurance company requires a prior authorization before a service or medication is rendered, a process fee of $25 is collected from the patient. Initiation of the prior authorization process is not a guarantee of approval of the request. The Approval or denial of the prior authorization request depends is made by your insurance company and often depends on the insurance company's medical guidelines and your plan policies. Please allow at least (5) business days for medication authorization and 5-10 days for procedure, DME or sleep study authorization. **Initial here: ______**
- **Phone calls**:
  By providing contact information I authorize Sleep Medicine Institute of Texas to use the information to contact me and to place calls to my home/cell phone/work phone and leave voicemails including appointment reminders, referrals, billing and insurance information. **Initial Here: _______**

Patient Name: ___________________________

Date of Birth: _________________

GENERAL POLICIES CONTINUED.

- **Medical Staff:** Sleep Medicine Institute of Texas has on staff Nurse Practitioners who assist in the delivery of medical care. A Nurse practitioner is a graduate of a certified training program including eight years of RN. BSN and MSN and is licensed by the state board. Under the supervision of the physician, the Nurse Practitioner can diagnose, treat and monitor common acute, chronic conditions and provide maintenance care. "Supervision" does not require the physical presence of the supervising physician but rather overseeing the activities of and accepting responsibility for the medical services provided.
- **Medical Records fee:** According to the Medical Records Release and Charges, Texas Administrative Code. Title 22, Part 9, Chapter 165, Section 65.2, Base medical records copy charges re $25 for the first twenty (20) pages, and $0.50 per page for every copy thereafter. Postage is additional and payment is required in advance. Sleep Medicine Institute of Texas will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed the form authorizing records 'release. Medical Record does not include billing records.
- **E-MAIL AND PATIENT PORTAL OPT-IN AGREEMENT:**

I acknowledge Sleep Medicine Institute of Texas has requested I register with the Patient Portal as a means of greater access and efficient communication. I understand this is a secure means of electronic communication that requires a password and email address to facilitate an exchange of information. I understand any electronic communication may contain personal information relating to my medical care. It is my responsibility to safeguard my password to the Patient Portal. An appointment reminder system will send an email to you with information regarding your office visit. Studies show that more than 70% of patients say reminders help them remember an appointment. Place your initials below to Opt-In and indicate that you would like to be included in this program.

Opt in
Opt out

I have read and understand the practice's general policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

____   ________________________

Print Name of patient   Date of Birth

____   _________________________

Signature of Patient/Guardian   Date

Patient Name: ____________________________

Date of Birth: _________________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that it is the policy of Sleep Medicine Institute of Texas, PA to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company (-ies) for payment of my claim, I would like for the following person/people to have access to my Private Health Information.

Name	Date of Birth	Relationship	Contact Number	Clinical Information	Financial information

________________________________ ______________________

Patient/ Guardian signature Date

ACCESS TO RESTRICTED INFORMATION

If you do not wish to share specific clinical information with any of the persons listed above please specify what clinical information you **DO NOT WISH** to share:

___Sexually transmitted diseases
___Terminal Illness
___Mental/behavioral health
___Pregnancy

________________________________ ______________________

Patient/ Guardian signature Date

ACKNOWLEDGMENT OF RECEIPT OF HIPPA NOTICE

I understand Sleep Medicine Institute of Texas, PA, has given me the opportunity to review a copy of the organization's Notice of Privacy Practices. My signature below constitutes my acknowledgement that I have been provided with an opportunity to receive a copy of the Notice of Privacy Practices.

________________________________ ______________________

Patient/ Guardian signature Date

________________________________ ______________________

Staff/ Witness signature Date