Connecticut Pulmonary Specialists
Pulmonary, Critical Care & Sleep Medicine
46 Prince Street • Suite 306 • New Haven, CT 06519 • (203) 786-5067 • Fax (203) 786-5162

Today's Date: ______________________________

Last Name: ___________________ First Name: ________________ MI: _____
Address: ____
City: ______________________ State: ______________ Zip Code: __________
Home Phone: _______________ Cell: ______________ Work Phone: ___________
DOB: _______________ Social Security Number: ________________________

Marital Status: M/S/D/W Male/Female Employer: _________________________
Ethnicity: Hispanic/Non-Hispanic Race: ____________ Language: ______________

Email: ______________________ **Pharmacy:** ____________________________

Primary Doctor: ___________________ **Referring Doctor:** _____________________

Responsible Party: (If same as above leave blank)
Last Name: __________________ First Name: ___________________ MI: ______
Address: ______________________ City: ___________________ Zip: ________

Emergency Contact:
Last Name: __________________ First Name: ___________________ MI: _____
Relationship: _________ Home Phone: __________ Cell: __________ Work: _______

Primary Insurance:
Insurance Name: ______________________ Patient/Subscriber Relationship: ________
ID Number: ___________________________ Group Number: ___________________

Secondary Insurance:
Insurance Name: ______________________ Patient/Subscriber Relationship: ________
ID Number: ___________________________ Group Number: ___________________

Authorization is hereby given to the Connecticut Pulmonary Specialists, PC to submit my claim directly to my insurance carrier on my behalf. I understand that by signing this form my signature is not needed each time a claim is submitted on my behalf. I hereby authorize my insurance carrier to submit payment directly to Connecticut Pulmonary Specialists, PC. I understand that I am financially responsible for all the charges whether or not paid by the insurance. I hereby authorize the release of all information necessary to secure payment.

____ ____________________

Signature (patient or parent of minor) Date

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Communications Request

As part of Practice Operations, we routinely contact our patients by telephone for a variety of reasons. This includes appointment scheduling and reminders, routine test results, procedure preparation and instructions, as well as responses to your questions.

We will telephone you at your home. If you are unavailable, we will leave a message on your answering machine or with whomever answers the telephone. In case of an urgent matter we will also attempt to reach you on your cell phone and/or work.

PLEASE INDICATE YOUR ACCEPTANCE OF THIS MATTER BY SIGNING BELOW.

Patient Signature ____________________________________ Date ___________________________

Printed Name: __________________________________

If the above manner of contact is not acceptable to you please indicate how you prefer to be contacted (I.e. alternate telephone number, mailing address)

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In addition, I authorize the following people to request information on my behalf either written or verbal regarding scheduling, test results, and procedures.

Spouse ___________________________ Significant Other____________________________________

Sibling ___________________________ Child____

Other ___________________________

____ ______________________________

Patient Signature Date

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Acknowledgement of receipt of Notice of Privacy Practices

Name of Patient ____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signature:______________________________ **Date:** ________________

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 48 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people. Office appointments which are cancelled with less than 24 hours notification may be subject to a $50.00 cancellation fee. Sleep study cancellations require 2 days advance notice, without notification they may be subject to a $200.00 cancellation fee. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments without new referral from primary doctor. Patients may also be subject to a $50.00 fee for office appointment No Show and $200.00 sleep study No Show fee. The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department. Please sign that you have read, understand and agree to this Cancellation and No show Policy.

Patient Name (Please Print) ______________________________

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Signature of Patient or Patient Representative