



**Pulmonary Disease and
Critical Care Associates, P.A.**

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Last Name _____ First Name _____ Middle Initial _____
 Address _____ City _____ State _____ Zip _____
 Home Phone () _____ Work/Cell Phone () _____ E-Mail _____
 Date of Birth _____ Age _____ SS# _____ Male _____ Female _____
 Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
 Employer _____ Employer's Phone () _____
 Employer's Address _____ City _____ State _____ Zip _____
 Referring Doctor _____ Phone () _____ - _____
 Primary Insurance Co _____ Policy # _____ Group # _____
 Policyholder _____ Relationship to Patient _____
 Date of Birth _____ SS# _____ Employer _____
 Secondary Insurance Co _____ Policy # _____ Group # _____
 Emergency Contact Name: _____ Relationship _____ Phone () _____
 Work/Cell Phone: () _____

Assignment of Insurance Benefits and Financial Responsibility Guarantee

I/we hereby assign any and all insurance benefits due and payable to me by any policy of insurance to Pulmonary Disease and Critical Care Associates, P.A. for services rendered. I/we further understand and agree that this assignment is non-revocable. I/we authorize any insurance company to pay benefits due directly to Pulmonary Disease and Critical Care Associates, P.A. and to release to my insurance carrier any medical records or other documents requested by the carrier which are deemed necessary by the carrier to process payments of the claim.

I/we understand that I/we personally guarantee to be financially responsible to pay Pulmonary Disease and Critical Care Associates, P.A. for any and all charges not covered by this assignment and all fees incurred by the practice in collecting all outstanding debts. Co-pay is due at the time of visit.

As a guarantor, I/we fully accept the medical services provided to the above named patient as full consideration for my signing this document.

Statement of Finance Charges

To avoid an additional finance charge on the balance of your account, pay the total amount due in full within ninety (90) days of the bill date. The rate of finance charges assessed is a monthly periodic rate of one and one-half percent (1-1/2%) for a corresponding annual percentage rate of eighteen percent (18%).

If you feel there is an error in this account, you must notify the doctor's office in writing within sixty (60) days of the bill date. You must supply a description of the error and an explanation of why you believe it is an error; the dollar amount of the suspected error, and any other information you believe may be helpful in resolving this matter. The doctor's office must acknowledge all letters pointing out possible errors within thirty (30) days of receipt of your written notice. Within ninety (90) days after receiving your letter, the doctor's office must either correct any error found or explain to you why the doctor's office believes the bill is correct.

I agree to pay any finance charges incurred by failure to pay the balance due on my account in full within ninety (90) days of the bill date.

I/we have read this document and I/we execute it with full knowledge and understanding of its contents and attest that all information is true and correct.

Witness Date

Patient's Signature Date

Witness Date

Guarantor's Signature Date