LOWOUNTRY LUNG AND CRITICAL CARE

DAVID K HANDSHOE,MD - THOMAS D KAELIN,JR, DO - JOHN M RUCKER,MD
SOLA KIM, MD - LESLIE D WILKE, DO - JARED M INTAPHAN, MD
MICHAEL A SPANDORFER, MD - RYAN LOK, DO - EMERALD R BRANCH,MD
JESSICA BROWN, PA- LAUREN DAVIS, PA-C - MORGAN RUBENSTEIN, APRN
K SCOTT MILLER, MD (RET)

PATIENT REGISTRATION FORM

PLEASE PRINT

Date_____

Patient_____
Last Name First Name M. Initial

Address _____Apt#_____

City_____State_____Zip Code_____

Phone #_____Sex: M ___ F___ Birthdate_____

Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino___ Other___Decline to say___

Race: Am Indian/Alaskan Native___Asian___Black or African Am___White___

Multiracial ___ Other Race___ Decline to say ___

Single ___ Married___ Widowed___ Separated___ Divorced___Other___Life Partner___

Cell#_____Social Security _____

Email Address_____

Patient Employed by_____

Spouse (or responsible party)_____Birthdate_____

EMERGENCY CONTACT

Name_____Phone#_____Relationship_____

==========

Primary Insurance_____

Secondary Insurance_____

List Allergies_____

Primary Care Doctor/Location_____

Who referred you here_____

Pharmacy Name/Phone #_____

OFFICE POLICIES

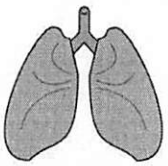
1. All payments for your medical services are due at the time of service. Expect to pay your co-payment, any remaining deductibles, or the percentage specified in your insurance contract at that time.
2. If our practice does not participate with your insurance, you are expected to pay the bill in full and we will provide assistance in filing the charges to your insurance company.
3. For your convenience, you may make payments by cash, personal check, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS or money order.
4. If you have no insurance, or an extremely large deductible, please notify our staff right away. We will work with you to arrange a payment schedule if you inform us of the circumstances up front.
5. If your insurance has not paid within 60 days of our filing, the bill becomes your responsibility in full.
6. There is a $40.00 charge for returned checks.
7. **THERE IS A CHARGE OF $25.00 FOR COMPLETION OF FORMS, OR LETTERS DICTATED BY A PHYSICIAN (DISABILITY, INSURANCE, SOCIAL SECURITY, FMLA AND MEDICAL RECORDS)**
8. We reserve the right to charge a fee of $25.00 for not canceling an appointment at least 24 hours in advance for a **NO SHOW**.
9. It is solely your responsibility to get authorization and referrals and to know the limitations of your insurance benefits.
10. If a test is not covered by your insurance, it will become the financial responsibility of the patient.
11. X-ray disks will be destroyed unless you ask to have them returned to you.

ASSIGNMENT AND RELEASE

In order to ensure proper follow-up and continuity of care, I agree that copies of my medical records may be released to my physician(s) I may be referred to and/or the provider who referred me to this practice. I request that payment of authorized benefits be made to **LOWCOUNTRY LUNG AND CRITICAL CARE, LLCC** and/or its doctors on my behalf for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, or any other government or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third-party payer. I authorize a copy of this authorization to be used in the place of the original, I authorize the use of this signature on all insurance submissions.

Signed_____ Date_____

Print Name_____



LOWCOUNTRY LUNG AND CRITICAL CARE

DAVID K HANDSHOE, MD - THOMAS D KAELIN, JR, DO -JOHN M RUCKER,MD
SOLA KIM, MD - LESLIE D WILKE, DO - JARED M INTAPHAN, MD
MICHAEL A SPANDORFER, MD - RYAN LOK, DO -
EMERALD R BRANCH, MD
JESSICA BROWN, PA - LAUREN DAVIS, PA-C
MORGAN RUBENSTEIN, APRN
K SCOTT MILLER, MD (RET)

MEDICAL RECORDS RELEASE FORM

TO:

_____

_____

_____

I hereby authorize you to release my medical records to:

9150-B MEDCOM ST., N. CHARLESTON, SC 29406 (P) 843-572-3330 (F) 843-572-1255

1938 Charlie Hall Blvd Unit A, Charleston, SC. 29414. (P) 843-763-3360. (F) 843-763-3038

300 Callen Blvd Ste 220. Summerville, SC (P)843-572-3330. (F) 843-572-1255

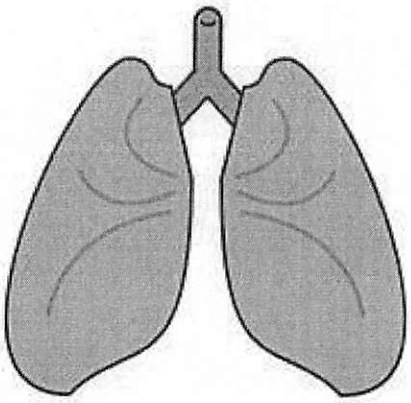
Please include any information including diagnosis and records of any treatment or examination rendered to me.

_____ **Date**

_____**Signature**

_____**Print Name**

VALID FOR 1 (ONE) YEAR FROM DATE OF SIGNATURE



LOWCOUNTRY LUNG AND CRITICAL CARE

- DISCLOSURES TO FAMILY MEMBERS AND FRIENDS -
(LIVING FAMILY / FRIENDS ONLY)

I, _____authorize **LOWCOUNTRY LUNG AND CRITICAL CARE** To disclose/ discuss my private information relating to my health or for payment of healthcare services to those listed below, if needed. I understand that only information relevant to my current treatment will be disclosed. I have agreed that **LOWCOUNTRY LUNG AND CRITICAL CARE**
May disclose health care information to:

NAME RELATIONSHIP

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT SIGNATURE: _____DATE:_____