

PATIENT INFORMATION PACKET



TRI-STATE SLEEP DISORDERS CENTER

www.tristatesleep.com

Tri-County Location
1275 E. Kemper Road
Cincinnati, OH 45246
(513) 671-3101



Tri-State Sleep Disorders Center

RELEASE OF INFORMATION

Patient consent for use and disclosure of confidential information for medical care and for payment purposes

The Tri-State Sleep Disorders Center recognizes the importance of patient privacy. Therefore, it is the policy of the Tri-State Sleep Disorders Center to treat all medical information as confidential. Except in extraordinary legal circumstances or in medical emergency circumstances, we will not disclose a patient's medical information without appropriate patient consent.

I, as the patient (or authorized representative of the patient), consent to the release of information about myself or regarding services rendered by this organization to the following entities:

My insurance company or any governmental payer of medical expenses.

My primary care physician and any other physicians I've listed or otherwise requested.

I understand that this consent to release information may include the release of personal and private medical information, if such a release is necessary for billing, claim processing and reimbursement purposes, or for purpose of subsequent medical care.

This consent is valid for the disclosure of medical information contained in print or in electronic form, including, but not limited to, electronic mail (e-mail) and facsimile.

This consent to release information may be revoked at any time and such revocation shall be effective immediately, except to the extent that this organization has already taken action in reliance upon my present consent.

Patient/Parent/Guardian Signature: _____ Date: _____



Tri-State Sleep Disorders Center

PATIENT REGISTRATION FORM

(Please fill out the blanks or circle your answers)

PATIENT NAME: _____ DATE OF BIRTH ____ / ____ / ____ GENDER: M F

ADDRESS: _____ CITY _____ STATE: _____ ZIP: _____

TELEPHONE: _____ SOC. SEC. # _____ MARITAL STATUS: M S D W

EMPLOYER: _____ TELEPHONE: _____

ADDRESS: _____ CITY _____ STATE: _____ ZIP: _____

EMPLOYMENT STATUS: FULL TIME PART TIME DISABLED RETIRED (WORKED UNTIL: ____ / ____ / ____)

PRIMARY CARE PHYSICIAN: _____ TELEPHONE: _____

ADDRESS: _____ CITY _____ STATE: _____ ZIP: _____

REFERRING PHYSICIAN: _____ TELEPHONE: _____

ADDRESS: _____ CITY _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT (not in your household): _____ RELATIONSHIP: _____

ADDRESS: _____ CITY _____ STATE: _____ ZIP: _____

TELEPHONE (HOME): _____ (WORK) _____

FINANCIALLY RESPONSIBLE PARTY (if it's the patient, write "PATIENT", otherwise complete this section)

NAME: _____

ADDRESS: _____ STATE: _____ ZIP: _____

TELEPHONE (HOME): _____ (WORK) _____

EMPLOYER: _____ EMPLOYER TELEPHONE: _____

PATIENTS RELATIONSHIP TO THE INSURED:

SELF SPOUSE CHILD

PLEASE NOTE: WE NEED BIRTHDATE AND

SOC. SEC. # OF INSURED

PRIMARY INSURANCE: _____ ID NUMBER _____

ADDRESS: _____ STATE: _____ ZIP: _____

INSURED'S NAME _____ DATE OF BIRTH ____ / ____ / ____ SOC. SEC. # _____

EMPLOYER'S NAME & ADDRESS: _____

SECONDARY INSURANCE: _____ ID NUMBER _____

ADDRESS: _____ STATE: _____ ZIP: _____

INSURED'S NAME _____ DATE OF BIRTH ____ / ____ / ____ SOC. SEC. # _____

EMPLOYER'S NAME & ADDRESS: _____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____



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PRIVACY POLICY

We here at the Tri-State Sleep Disorders Center are vigilant to protect patient confidentiality. No information regarding our patients is shared or distributed with any person or organization without the patient's signed authorization. Any questions or comments may be directed to our Privacy Compliance Officer. Please complete by signing and dating.

Patient Signature _____ Date _____



Tri-State Sleep Disorders Center

PAYMENT AGREEMENT

Regardless of insurance benefits (if any) or the designation of some other responsible party above, **I understand that I am financially responsible for the fees.** I understand that it is my responsibility to obtain and maintain a current **referral** (if required) and to pay any deductibles, co-payments and or co-insurance not covered by the insurance plan or governmental program. Although the Tri-State Sleep Disorders Center will take reasonable steps to obtain reimbursement from the insurance company or the person(s) listed above as being financially responsible, I agree that it is ultimately **my responsibility** to seek reimbursement for the medical bills from the insurance company or from the financially responsible party. Further, in the event of payment default, I agree to pay all collection costs in excess of the initial fees, including any legal expenses.

If I am covered my **Medicare**, I understand that if I am provided specific written notice, in advance, that Medicare is not likely to cover a particular visit or procedure, I will be responsible to pay for that procedure or visit, if I then agree to proceed with that procedure or visit.

I hereby authorize the Tri-State Sleep Disorders Center to file claims on my behalf for covered services and direct my insurer and/or government payer to make payment of my medical benefits directly to this organization for the services they have provided to me.

I certify that the information given by me here, for the purposes of my medical care and payment for it, is correct to the best of my knowledge.

I have read and I understand this document and agree to its provision.

Patient/Parent/Guardian Signature: _____ Date: _____