sleephealth
clinic of The Woodlands

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The Woodlands, TX 77381
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PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____
Last First MI

Address: _____
Street or P.O. Box City State Zip

Home # (_____) _____ Work # (_____) _____ Cell # (_____) _____

Email: _____ Fax # (_____) _____

Emergency Contact: _____ Phone: (_____) _____

Social Security (*required*) # _____ Date of Birth: _____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑Married ❑Divorced ❑Widowed Spouse's Name: _____

Employer: _____ ❑Part Time ❑Full Time ❑Retired ❑Student ❑None

Referring Physician: _____ Phone: (_____) _____

Primary Care Physician: _____ Phone: (_____) _____

Preferred Pharmacy: _____ Phone: (_____) _____

RESPONSIBLE BILLING PARTY

Please complete if the responsible billing party is different from the person listed above.

Name: _____ Phone: (_____) _____

Address: _____
Street/P.O. Box City State Zip

Relationship to Patient: ❑Spouse ❑Parent ❑Partner ❑Other (please specify):_____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ **Employer:** _____

Policy Holder: _____ **Date of Birth**: _____
Last First MI

Social Security #: _____ **Member ID:** _____ **Group #:** _____

If you have a Secondary Policy please list the name: _____

DOES YOUR PLAN REQUIRE REFERRALS FOR SPECIALIST OFFICE VISIT? ❑ **YES** ❑ **NO**

IF YOU MARKED YES – PLEASE NOTE THAT REFERRALS ARE NEEDED FOR ALL SERVICES PROVIDED AT OUR CENTER, INCLUDING SLEEP STUDIES AND MEDICAL EQUIPMENT. - Thank You

RELEASE OF INFORMATION

I hereby authorize Sleep Health Clinic of The Woodlands to obtain/release my information from/to any medical provider such as physician, medical equipment company, or hospital - as well as any insurance company and/or responsible billing party. This information may include diagnosis, records of any treatment, or any examinations rendered.

In addition to the above release, I authorize Sleep Health Clinic of The Woodlands to release any information to: **Please print name(s)**

☐ Spouse: _____ ☐ Parent: _____

☐ Other: _____

ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance benefits directly to Sleep Health Clinic of The Woodlands otherwise payable to me. I have provided the Sleep Health Clinic of The Woodlands a complete list of the insurance companies with which I have Medical coverage.

CONSENT TO TREAT

I authorize Sleep Health Clinic of The Woodlands and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf.

FINANCIAL AGREEMENT

Unless other arrangements have been made in advance by either you or your health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal check, Visa, MasterCard, and Discover. There will be a $35 fee on any returned checks.

We are contracted providers with many health plans. We agree to submit a claim to your insurance plan, regardless of whether we have a contract with them. You are required to pay your plan authorized deductible and co-payment at the time of service. After the claim has been considered, we will bill you for any balance not previously paid.

Your insurance policy is a contract between you and your insurance company; your doctor is not involved. If you have questions or concerns regarding your plan's coverage on procedures, services, medications or particular conditions, you are responsible for obtaining this information prior to your appointment. You agree to pay in full for all services not covered by your insurance plan and/or responsible billing party.

Should your insurance company/responsible billing party not pay for the services provided, you agree to pay all charges incurred. Each bill is due upon receipt. Should the account become delinquent, you agree to pay all costs of collection, including interest applied by a collection agency and attorney fees.

PRIVACY PRACTICES

I understand that Sleep Health Clinic of The Woodlands may obtain/disclose my health information in order to:

1. make decisions about, and plan for my care and treatment:
2. refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
3. determine eligibility and coverage guidelines from the responsible billing party and/or insurance plan
4. perform all necessary functions involved in receiving payment for services rendered

I understand that I also have the right to receive and review a written description of how Sleep Health Clinic of The Woodlands will handle health information about me.

I have read all of the information provided to me by Sleep Health Clinic of The Woodlands. By signing this document I agree to and understand all of the information listed above.

_____ _____

Signature of Patient or Guardian Date